BUILDING SCHOOL READINESS THROUGH HOME VISITATION

Prepared for the First 5 California Children and Families Commission
2389 Gateway Oaks, Suite 260
Sacramento, CA 95833

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Prepared for the First 5 California Children and Families Commission by:

Deanna S. Gomby, Ph.D., M.S.
Deanna Gomby Consulting
903 Sunrose Terrace, #206
Sunnyvale, California 94086
(408) 736-8450

eleganttern@earthlink.net

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In 2001, the First 5 California Children and Families Commission[a] adopted an overarching criterion by which to judge the success of the California Children and Families First Act: "All young children healthy, learning, and ready to succeed in school."[1] Adapted from the National Education Goals Panel, the Commission defines school readiness as requiring ready children, ready families and communities, and ready schools.

Home visitation is one of the most commonly used service approaches in serving families with young children, reaching as many as 550,000 children and families annually across the nation.[2] At least 37 states have state-based home visiting systems,[3] many as part of school readiness initiatives. Most California counties have elected to use some of their First 5 dollars for home visiting.[4]

Home visiting is being embraced nationally and in California because it has been used to address many goals important for young children and their families, including many of those specified as part of the school readiness definition adopted by the First 5 California Children and Families Commission. (See Table 1) Home visiting is promoted as a strategy that can bring services to socially or geographically isolated families, and through which services can be tailored to meet the needs of individual families.

This paper explores the extent to which research indicates that home visitation can be used as a school readiness strategy. Although there are many different types of home visiting programs, this paper focuses on a subset of home visiting programs – those primary prevention programs that send individuals into the homes of families with pregnant women, newborns, or very young children and seek to improve the lives of the children by encouraging change in the attitudes, knowledge, and/or behaviors of the parents. The following are the main conclusions:

- The popularity of home visiting has been driven by the results of a few studies of programs such as the Nurse-Family Partnership that demonstrate long-term benefits for parents and children.
- Generally, however, results vary widely across program goals, program models, program sites implementing the same model, and families within a single program site.

[a] In Fall 2002, the California Children and Families Commission changed its name to the First 5 California Children and Families Commission.

- Home visiting programs *can* produce benefits associated with school readiness for children and parents, but such benefits are often modest in magnitude, and more often observed among parents and in parent behavior than among children.
- Home visiting programs are most effective in promoting school readiness outcomes when they maintain a clear focus on their goals; are linked with other services, especially those that offer services directly focused on the child; and when the home visiting and associated services are of the highest quality.

Table 1

The Relationship of Home Visiting to the School Readiness Goals of The First 5 California Children and Families Commission

The First 5 California Children and Families Commission specified that school readiness includes three main components (ready children, ready families and communities, and ready schools), each of which is characterized by several attributes. Home visiting programs have been hypothesized to influence the attributes in **bold**.

Children's readiness for school:

- **Physical well-being and motor development**
- **Social and emotional development**
- Approaches to learning
- **Language development**
- **Cognition and general knowledge**

Schools' readiness for children

- **A smooth transition between home and school**
- **Continuity between early care and education programs and elementary grades**
- A student-centered environment focused on helping children learn
- A commitment to the success of every child
- Approaches that have been shown to raise achievement for each student
- A willingness to alter practices and programs if they do not benefit children
- Assuring that their students have access to services and supports in the community

Family and community supports and services that contribute to children's readiness for school success

- Access to high-quality and developmentally appropriate early care and education experiences
- **Access by parents to training and support that allows parents to be their child's first teacher and promotes healthy functioning families**
- **Prenatal care, nutrition, physical activity, and health care that children need to arrive at school with healthy minds and bodies and to maintain mental alertness**

SOURCE: California Children and Families Commission. (2001) *Guidelines and Tools for Completing a School Readiness Application.*

These findings suggest that program planners and funders, including Proposition 10 county commissions, should maintain modest expectations for what home visiting can accomplish, should embed home visiting services in a coherent system of services for families and children, and, above all, should focus on making sure that the home visiting services that are offered in their counties are of the highest quality. Specific recommendations are summarized in Box 1.

Box 1.
Summary of Suggestions for Program Planners

1. **Maintain realistic expectations for what home visiting services can accomplish.**

2. **Make each funded home visiting program a strong, high quality program.**

   a. Program funders and funding agencies, including county First 5 Commissions should:
      (1) Before launching a program, consider carefully the role that home visiting is likely to play in promoting school readiness.
      (2) Select a program model whose curriculum clearly addresses the goals targeted by the county.
      (3) Consider carefully which agency will administer the proposed home visiting program, and the implications of that choice.
      (4) Support the costs of program monitoring and quality improvement, including data collection, MIS development, data analysis and feedback to program sites.
      (5) Facilitate the development of common definitions among funded programs for key program quality components (e.g., terms such as enrollment, attrition, missed visit, reasons for exit, paraprofessional).
      (6) Require reporting around key program quality components, using common definitions if they have been developed, or asking programs to include their definitions if common definitions are not yet developed.
      (7) Support opportunities for rapid improvement cycles.

   b. Individual program sites should:
      (1) Make sure that they adhere to program standards established by the national headquarters for their program model.
         (a) If programs are not affiliated with a national model, then they should make sure that they establish standards for the key components of program quality (e.g., family engagement, curriculum, staffing, cultural consonance, and services tailored to high-risk families).
         (b) If national offices have not yet established such standards, local program planners and funders should urge them to do so, and they should consider seriously selecting another model that has such standards in place.
      (2) Hire, train, and retain the best home visitors available.
      (3) Monitor performance on program standards regularly and provide feedback to staff.
      (4) Seek out opportunities for cross-site comparisons on performance standards, and for follow-up learning to figure out what contributes to the varying performance at each site.
      (5) Within a site, try out rapid improvement cycles, to test strategies to address quality problems.
      (6) Make sure that services are culturally appropriate.

3. **Coordinate home visiting services and resources within each county.**
   a. Before launching a new home visiting program, local First 5 Commissions should sponsor a survey of existing home visiting programs within the county.

   b. Coordinate referrals to home visiting programs.

   c. Coordinate messages across home visiting programs and across other service programs within the community.

   d. Require common definitions and terminology in reports on home visiting services from all agencies and organizations funded with First 5 dollars.

   e. Coordinate the training of home visitors to save resources, build camaraderie, and help programs learn from one another.

4. **Embed home visiting services in a system that employs multiple service strategies, focused both on parents and children.**
   a. To strengthen parenting and promote children's health and development, create a strong system of services that includes health insurance coverage, child-focused child development services, and home visiting.

   b. Include services that are focused both on parents and on children.

   c. Offer multiple approaches for parent-focused services (e.g., both home visits and parent support groups).

   d. Consult with families regularly to make sure that the mix of services is appropriate.

Endnotes

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Deanna S. Gomby, Ph.D., M.S.
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I. INTRODUCTION AND MAIN POINTS

In 2001, the First 5 California Children and Families Commission[b] adopted an overarching criterion by which to judge the success of the California Children and Families First Act: "All young children healthy, learning, and ready to succeed in school."[1] Adapted from the National Education Goals Panel, the Commission defines school readiness as requiring ready children, ready families and communities, and ready schools.

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Home visiting is being embraced nationally and in California because it has been used to address many goals important for young children and their families, including many of those specified as part of the school readiness definition adopted by the First 5 California Children and Families Commission. (See Table 1) Home visiting is promoted as a strategy that can bring services to socially or geographically isolated families, and through which services can be tailored to meet the needs of individual families.

This paper explores the extent to which research indicates that home visitation can be used as a school readiness strategy. Although there are many different types of home visiting programs, this paper focuses on a subset – those primary prevention programs that send individuals into the homes of families with pregnant women, newborns, or very young children and seek to improve the lives of the children by encouraging change in the attitudes, knowledge, and/or behaviors of the parents. The following are the main conclusions:

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- Home visiting programs are most effective in promoting school readiness outcomes when they maintain a clear focus on their goals; are linked with other services, especially those that offer services directly focused on the child; and when the home visiting and associated services are of the highest quality.

These findings suggest that program planners and funders, including Proposition 10 county commissions, should maintain modest expectations for what home visiting can accomplish, should embed home visiting services in a coherent system of services for families and children, and, above all, should focus on making sure that the home visiting services that are offered in their counties are of the highest quality. Specific recommendations are summarized in Box 1, and explained in greater detail in Suggestions for Program Planners (Section VI).

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SOURCE: California Children and Families Commission. (2001) *Guidelines and Tools for Completing a School Readiness Application.*

This paper describes home visiting programs, including some of the largest national models in the United States (Section II); then summarizes the literature on the effectiveness of home visiting in building school readiness both when home visiting is the primary service strategy (Section III), and also when it is linked with other services (Section IV). Research on the importance of high-quality implementation of services in developing strong home visiting programs is summarized in Section V. All the research findings are distilled into recommendations for program planners and conclusions (Sections VI and VII).

Appendices (A-E) provide extensive detail: Appendix A is the detailed literature review that forms the basis for this paper; Appendix B is an annotated bibliography of the most recent studies, literature reviews, and meta-analyses for readers seeking additional information; Appendix C describes the major home visiting programs in the United States and their presence in California; Appendix D describes some community-wide home visiting efforts in Alameda County, California, and Cuyahoga County, Ohio; and Appendix E contains answers to Frequently Asked Questions (FAQs) often posed by program planners who are considering implementing home visiting.

Box 1.
Summary of Suggestions for Program Planners

1. Maintain realistic expectations for what home visiting services can accomplish.

2. Make each funded home visiting program a strong, high quality program.

a. Program funders and funding agencies, including county First 5 Commissions should:
   (1) Before launching a program, consider carefully the role that home visiting is likely to play in promoting school readiness.
   (2) Select a program model whose curriculum clearly addresses the goals targeted by the county.
   (3) Consider carefully which agency will administer the proposed home visiting program, and the implications of that choice.
   (4) Support the costs of program monitoring and quality improvement, including data collection, MIS development, data analysis and feedback to program sites.
   (5) Facilitate the development of common definitions among funded programs for key program quality components (e.g., terms such as enrollment, attrition, missed visit, reasons for exit, paraprofessional).
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b. Individual program sites should:
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      (b) If national offices have not yet established such standards, local program planners and funders should urge them to do so, and they should consider seriously selecting another model that has such standards in place.
   (2) Hire, train, and retain the best home visitors available.
   (3) Monitor performance on program standards regularly and provide feedback to staff.
   (4) Seek out opportunities for cross-site comparisons on performance standards, and for follow-up learning to figure out what contributes to the varying performance at each site.
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3. **Coordinate home visiting services and resources within each county.**
   a. Before launching a new home visiting program, local First 5 Commissions should sponsor a survey of existing home visiting programs within the county.

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   c. Coordinate messages across home visiting programs and across other service programs within the community.

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   e. Coordinate the training of home visitors to save resources, build camaraderie, and help programs learn from one another.

4. **Embed home visiting services in a system that employs multiple service strategies, focused both on parents and children.**
   a. To strengthen parenting and promote children's health and development, create a strong system of services that includes health insurance coverage, child-focused child development services, and home visiting.

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   c. Offer multiple approaches for parent-focused services (e.g., both home visits and parent support groups).

   d. Consult with families regularly to make sure that the mix of services is appropriate.

II. BACKGROUND

The home visiting programs discussed in this paper are primary prevention programs, beginning prenatally or soon after birth, and continuing for as long as the first 3 or 5 years of the child's life. These programs include nationally known models such as Early Head Start, Healthy Families America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), the Nurse-Family Partnership (NFP), Parents as Teachers (PAT), and the Parent-Child Home Program (PCHP). Together, these programs have thousands of sites across the nation, each has multiple sites in California, and some have inspired the development of home-grown models such as California's Cal-SAHF or ABC programs.

These national models are the home visiting programs whose goals are most closely aligned with the school readiness focus of the California Children and Families Commission, and all have been funded in communities across the country to promote school readiness or children's early learning. Specifically, these programs seek to:

- Promote enhanced parent knowledge, attitudes, or behavior related to childrearing;
- Promote children's health;
- Promote children's early learning and development;
- Prevent child abuse and neglect; and/or
- Enhance mothers' lives (e.g., decrease stress, provide social support, decrease rates of subsequent births and tenure on welfare rolls, and increase employment and education).

Home visiting programs share a reliance on a service delivery strategy (the home visit), but they differ in many ways, including in their goals, intensity of services, staffing, and whom they serve. Table 2 summarizes the basic elements of the largest national home visiting models. (See Appendix C for in-depth descriptions of each program model, profiles of California program sites for each model, and a listing of contact information for California program sites).

The differences among home visiting programs are not trivial. They have important implications for which program models should be selected for use in any community, for the families they are most likely to benefit, and for the likelihood that home visitor and parent will be able to form the close rapport that is the mechanism by which home visiting services work to generate change in parents or children. In other words, communities should select home visiting programs that clearly have the goals they are seeking to address, that have been demonstrated to work well with the families they are seeking to serve, and that employ home visitors who are appropriately trained to serve the families they are seeking to serve. (See Appendix E (FAQ2): What Home Visiting Model Should Be Selected?)

TABLE 2. DESCRIPTIONS OF KEY NATIONAL HOME VISITING PROGRAM MODELS (as of February 2002)

	Program Goals	Onset, Duration, and Frequency of Home Visits	Population Served	Background of Home Visitors	Training Requirements for Home Visitors
Early Head Start 664 sites nationally 53 sites in California	• Promote healthy prenatal outcomes for pregnant women • Enhance the development of very young children • Promote healthy family functioning	For home-based Early Head Start model only: Birth through age 3 Weekly home visits	Low-income pregnant women and families with infants and toddlers; 10% of children may be from families with higher incomes; 10% of program spaces reserved for children with disabilities	No specific requirements, although infant and toddler backgrounds preferred	Vary by program. Staff development plans and ongoing professional development required.
Healthy Families America 450 sites nationally 2 sites in California	• Promote positive parenting • Prevent child abuse and neglect.	Birth through 5th birthday Weekly, fading to quarterly	Parents in the mainland U.S. and Canada, all income levels and ethnicities, who are identified at the time of birth as at-risk for abuse and neglect	Paraprofessionals and Bachelor degrees	One week of pre-service training; 1 day of continuing training quarterly; 80 hours of additional training in the first 6 months of service are recommended by Prevent Child Abuse America.
The Home Instruction Program for Preschool Youngsters (HIPPY) 160 sites nationally 11 sites in California	• Empower parents as primary educators of their children • Foster parent involvement in school and community life • Maximize children's chances for successful early school experiences	Academic year, or two years before, and through the end of kindergarten Bi-weekly, i.e., at least 15 times, over 30 weeks during the school year	Families in the United States and Guam; all ethnicities; many low-income and with limited formal education.	Paraprofessionals, typically members of the community and former HIPPY parents. Most work part-time (20-25 hours/week)	Two-day pre-service training in the HIPPY program model, plus weekly ongoing training and staff development.

	Program goals	Onset and duration	Population served	Background of home visitors	Training requirements for home visitors
The Nurse-Family Partnership 250 sites nationally 11 sites in California (1 to open Fall 2002)	• Improve pregnancy outcomes • Improve child health and development • Improve families' economic self-sufficiency	Prenatal through 2nd birthday Weekly, fading to monthly	Low-income, first time mothers, all ethnicities	Public health nurses	Two weeks of training in the program model over the first year of service. Forty-six hours of continuing education in assessing parent-infant interaction, plus additional continuing education as needed.
The Parent-Child Home Program 132 sites nationally 4 sites in California (1 to open Fall 2002)	• Develop children's language and literacy skills • Empower parents to be their children's first and most important teachers • Prepare children to enter school ready to learn • Enhance parenting skills • Prepare children for long-term academic success and parents to be their children's lifelong academic advocates	Typically 2nd through 4th birthdays, but as young as 16 months (two years total) Two visits/week	Families in the United States, Canada, Bermuda, and the Netherlands; low-income, low-education families; all ethnicities; families with English as a Second Language; teen parents; homeless families	Paid paraprofessionals from the community, many previously parents in the program. Small number of volunteers, who may be professional.	16 hours of training prior to becoming a home visitor. Weekly minimum two-hour ongoing training and supervision session.
Parents As Teachers 2,879 sites nationally 88 sites in California	• Empower parents to give their child the best possible start in life • Give children a solid foundation for school success • Prevent and reduce child abuse • Increase parents' feelings of competence and confidence; • Develop home-school-community partnerships on behalf of children	Prenatal through 3rd birthday; may extend through 5th birthday Monthly, biweekly, or weekly, depending upon family needs and funding levels	Families in the United States and six other countries, all income levels and ethnicities.	Paraprofessionals, and AA, Bachelor, and advanced degrees	One week of pre-service training, 10-20 hours of in-service training, annual credentialing by the Parents As Teachers National Center

Note: By Jan 2003, 51 sites Early Head Start sites and 109 Parents as Teachers sites operated in California.
Source: National program offices and websites for each home visiting model. See Appendix C for additional details, including contact information.

III. DO HOME VISITATION PROGRAMS BUILD SCHOOL READINESS?

Given all the differences across programs, do home visiting programs help produce "ready families and communities," "ready children," and "ready schools?"

The brief answer is, "They can, but they do not always do so." The popularity of home visiting has been propelled by the findings of large and long-term benefits in a few studies (most notably, the studies of the Nurse-Family Partnership). But, in practice, results vary widely across program goals, program models, different sites implementing the same model, and different families within a single site. Further, when benefits are achieved, they are often small in magnitude. Across evaluations of many different home visiting models, the most rigorous studies show that programs are more likely to produce benefits in outcomes related to families (i.e., in aspects of parenting and, perhaps, prevention of child abuse and neglect), than in outcomes related to children (i.e., children's health or cognitive development). Less rigorous, qualitative research suggests that school-based home visiting programs may help parents become more involved with their children's schools in later years. Families that seek out services because their children have been identified as needing extra help, perhaps because they were born low birth weight or with other biological or developmental problems, are more likely to benefit from home visiting services than those families that are offered services primarily because they are socially at-risk (e.g., low income).

Table 3 summarizes the conclusions reached in eight recent meta-analyses (a special kind of literature review) concerning home visiting, and the right-most column in the table summarizes the conclusions reached in this paper. The conclusions in this paper are based on these eight meta-analyses plus additional studies and literature reviews (see Appendices A and B for details).

Table 3 illustrates both the wide-ranging goals that home visiting programs have been designed to address and the wide-ranging conclusions researchers have reached about whether or not the programs have succeeded in reaching their goals. The variability in researcher opinion is related to (1) the studies that they included in their reviews (e.g., international versus only United States programs; family support versus only home visiting programs; home visiting plus other services or only home visiting services; programs serving families with children with identified biological problems versus families whose only risk factor is low income); and (2) the willingness of the researchers to draw conclusions from sometimes small numbers of studies.

Despite the variability in researcher conclusions, however, Table 3 illustrates three important points:

- Evaluators have assessed the effectiveness of home visiting in promoting change in at least 14 broad categories of outcomes, each of which can be related to the school readiness definition adopted by the First 5 California Children and Families Commission.

Table 3.
Summary of Meta-Analyses and Overall Conclusions about the Effects of Home Visiting

	Abt Associates (Short-Term)[5]	Abt Associates (Follow-Up)[5]	Appelbaum & Sweet[6]	Elkan et al[7]	Roberts et al[8]	Guterman[9]	MacLeod & Nelson[10]	Hodnett[11]	CONCLUSIONS
READY FAMILIES AND COMMUNITIES									
Parenting Knowledge/Attitudes/ Behavior (HOME)	.18/.25/.30	-/.18/ -	.10	+		+			+
Child Health and Safety									
Nutrition: Breastfeeding/Diet				+/?					-
Preventive Health Services & Medical Home				-					-
Child Health Status									
Birth Outcomes: Preterm Birth and LBW								-	-
Child Health Status and Physical Growth	.09	-		-					-
Child Safety	.15	-							
Home Safety Hazards									
Unintentional Injuries				+					
Child Abuse and Neglect			.17-.48	?	?		.41		+
Maternal Life Course									
Stress, Social Support, Mental Health	.09	.17	-	+/?					-
Economic Self-Sufficiency	.10	.39	-	?					?
Education			.11	?					?
READY CHILDREN									
Children's Cognitive and Language Development, Academic Achievement	.09/.26/.36*	.30		+					-
Social and Emotional Development, Child Behavior	.15	.09		+					?
READY SCHOOLS									
Parental Involvement with Children's Education/School Events									?

Notes: + indicates positive effect shown; - indicates no effect; ? indicates not enough adequate studies to draw a conclusion.
Numerical values are in standard deviation units. Variation across meta-analyses driven by the studies included. Abt Associates: U.S. only; family support (not just home visiting) programs, unless otherwise noted. Hodnett: broad-based social support. Elkan et al, Roberts et al, MacLeod & Nelson, and Hodnett: home visiting only, but include international studies. Elkan et al and Abt Associates (except where otherwise noted) include children with special needs.
* Only home visiting programs: .09=untargeted population; .26=both special needs and other children; .36=targeted to children with special needs only. See also Appendices A and B for details about and key findings from each meta-analysis.

- On average, home visiting programs have rarely produced effects exceeding .20 of a standard deviation in size – a magnitude of effect that is considered small in the human services arena. This means that home visiting programs will rarely produce large, easily-observed changes across most of the families they serve. Change will be especially difficult to detect if small numbers of families are being served in any one program or if the measures used to detect change are not very sensitive. Program planners should therefore moderate their expectations about just how much change any home visiting program can produce.

- Home visiting may be more effective at producing some outcomes than others.

The following sections summarize the research findings, organized by the three major outcome areas mentioned in the school readiness definition adopted by the First 5 California Children and Families Commission: (1) Ready Families and Communities; (2) Ready Children; and (3) Ready Schools.

A. Ready Families and Communities

Some of the strongest benefits of home visiting are found in outcomes related to Ready Families and Communities. As defined by the First 5 California Children and Families Commission, this area includes parenting, child maltreatment, changes in the home environment, child health and safety, and maternal self-sufficiency. It is in the parenting and child maltreatment areas that home visiting programs may have their strongest effects.

1. Parenting

The most consistent benefits of home visiting programs are found in domains related to parenting such as parent attitudes, knowledge about child development, or parenting behavior, rather than in areas such as child development, child health, or maternal economic self-sufficiency.

The parents who show the greatest improvement in parenting behavior are those who entered the home visiting program because their children were identified as having behavior problems.[5] These parents may benefit most because they may have sought out services to help address specific problems, and they may therefore be especially motivated to change their own behavior. Of course, most of the home visiting programs that have been promoted to build school readiness do not recruit families with already-identified problems, but rather seek to support families before problems develop. Those primary prevention home visiting programs may therefore face a heavy burden to generate change because parents may not yet see any reason to change their parenting behavior.

2. Child maltreatment

Some programs are associated with changes in parent-child interaction or the prevention of child abuse and neglect, depending upon how these changes are measured. Changes are more likely to be detected in paper-and-pencil tests of parents attitudes

toward discipline or in the rates of usage of the emergency room for injuries and ingestions than in confirmed rates of child abuse and neglect, for example. Nevertheless, the areas of parenting and the prevention of child maltreatment are probably where home visiting programs have their strongest effects.

On the strength of these results, organizations such as the United States General Accounting Office[12], the U.S. Advisory Board on Child Abuse and Neglect[13], the American Academy of Pediatrics[14], the Association of Maternal and Child Health Programs[15], the Centers for Disease Control and Prevention (CDC)[16], the Office of Juvenile Justice and Delinquency Prevention[17], the National Academy of Sciences[18], and the National Governors Association[19], and have all endorsed the use of home visiting to prevent child maltreatment. In conjunction with the CDC, the Task Force on Community Preventive Services has concluded that up to 40% of all child maltreatment could be prevented if home visiting were widely available.[20]

The 40% estimate may be high because studies suggest that home visiting programs are not equally effective with all families. Different research teams have concluded that the programs that are the most effective in preventing child abuse and neglect are those that (1) serve mothers who have low coping skills; [21] and (2) serve families with relatively few episodes of domestic violence;[22] or are those that (1) serve families with children under age 3; (2) provide case management services; (3) serve teen parents; and (4) provide parent-child activities.[5]

3. Home environment

Changes in the home environment – either to make it safer or more likely to promote early literacy or child development – occur, but they are more rare than change in parenting attitudes or parent knowledge about child development.

4. Child health

Many home visiting programs (notably, many sites of the Healthy Families America program) have demonstrated that the families enrolled in their services achieve very high rates of immunizations or connections with a medical home.[23] Limited evidence suggests that home visiting programs may be helpful in promoting breastfeeding.[7] When tested with rigorous methods that compare home-visited families with randomly assigned control groups in the community, however, most home visiting programs have not increased the utilization of preventive health care, or improved children's diets (with the exception of breastfeeding), health status, or physical growth. The major determinant of children's utilization of health care is probably the availability of health care services within the community, which is driven by factors such as the availability of health insurance or transportation to health care clinics rather than the presence or absence of a home visiting program.

5. Maternal self-sufficiency

When tested with rigorous methods, most home visiting programs have not improved mothers' self-sufficiency (e.g., increased education, employment or income; deferred second pregnancies; decreased stress or mental health problems), but there is tantalizing

evidence from at least one home visiting program that home visiting can improve mothers' lives.

The Nurse-Family Partnership (NFP) is one of the few home visiting programs with a long-term follow-up. In Elmira, New York, over the course of 15 years after the birth of their children, poor unmarried women who had been home-visited had fewer subsequent pregnancies and births, were more likely to delay a second birth, spent fewer months on welfare or receiving food stamps, and had fewer problems due to substance abuse and fewer arrests than their counterparts in the control group. These were large differences: 60 versus 90 months on welfare, for example, and 65 versus 37 months between first and second births,[21] and a 1998 RAND Corporation study concluded that the program returned 4:1 savings to government, when it was offered to a high-risk population.[24]

But, in Memphis, the second NFP site, while subsequent pregnancies were deferred, they were not postponed as long as they had been in Elmira (a 67% reduction in Elmira versus 23% in Memphis at the end of program services), and there were no differences in employment or receipt of AFDC.[21] Follow-up is continuing to determine whether increased benefits will be observed in Memphis over time as they were in Elmira.

Few other programs have assessed economic self-sufficiency of the mothers, but, of those that have, many have found no benefits, or much smaller benefits. For that reason, no firm conclusions are drawn about the benefits of home visiting in this area.

B. Ready Children

Children's cognitive, language, and social and emotional development are all part of the definition of Ready Children. Home visiting programs may not be as effective in promoting clear changes in children as they are in helping change behavior of parents.

1. Cognitive child development

Some studies of programs such as Parents as Teachers,[25] HIPPY,[26] or the Parent-Child Home Program[27] have demonstrated that home visited-children out-perform other children in the community through the 4th, 6th, or 12th grades on measures such as school grades and achievement test scores on reading and math, suspensions, or high school graduation rates. However, large cognitive benefits such as these are *not* demonstrated reliably in randomized trials of home visiting programs.

In most studies, some subgroups of children do benefit, but the subgroups are not consistent across studies or across different sites of the same program model. For example, in an evaluation of HIPPY, children's cognitive development, school achievement, and classroom adaptation were assessed for two cohorts of children at each of two program sites and at two points in time. No clear pattern of results emerged: children in the first cohort benefited on some measures at one site but not at the other, or at one point in time but not at the other, and children in the second cohort did not benefit at either site.[28] Similarly mixed results can be found for many other home visiting programs.

Home visiting programs that serve socially at-risk (e.g., low income populations) generate small cognitive benefits of about .09 of a standard deviation; but programs that serve both biologically at-risk (e.g., child born low birth weight or with special physical needs) and socially at-risk children produce cognitive benefits that are about 3 times larger; and programs that serve only children with special needs produce benefits that are about 4 times larger.[5] In other words, as was the case concerning parenting behavior, cognitive benefits are largest when parents enroll in services because their child has a clear need for extra intervention. The larger benefits may reflect enhanced parental motivation to change their own behavior and to encourage change in their children, or it may reflect that change is easiest to produce and detect among those children who have the greatest distance to improve.

2. Social development

Social development benefits are elusive, although the NFP has found significant long-term benefits in children's behavior 13 years after services ended in Elmira, New York, when the children were 15 years of age. Benefits included fewer instances of running away, arrests, convictions, cigarettes smoked per day, and days having consumed alcohol in the last six months, less lifetime promiscuity, and fewer parental reports that children had problems related to drug or alcohol use.[21] Only a few other home visiting programs have followed families over time; and short-term social development benefits are rarely observed among children.

C. Ready Schools

Little research has examined the linkages between schools and home visiting programs, but many PAT, PCHP, and HIPPY programs are administered through school districts, and two descriptive studies of PAT and HIPPY suggest that home visiting linked with schools may result in parents becoming more involved in their children's schools, as evidenced by their attendance at special events in the school, work as school volunteers, participation in PTA meetings, communication with teachers, and assistance with homework.[29,30] This under-studied area may be a fruitful one to explore in future evaluations.

IV. DELIVERING HOME VISITS IN COMBINATION WITH OTHER SERVICES

The very mixed results reported above are derived from studies of programs in which home visiting was the primary service strategy. Would benefits be larger if home visiting were combined with other service strategies?

For child development and especially cognitive development outcomes, the answer is a clear "yes." Over the past 30 years, the early childhood programs that have produced the most substantial long-term outcomes for children were those that combined center-based early education services for children with significant parent involvement through

home visiting, joint parent-child activities, parent groups, or some other means.[31] In these programs, children demonstrated benefits in academic achievement throughout their school years, and were more productive citizens (committed fewer crimes and displayed less delinquent behavior, for example) as young adults. Similarly, interim results for Early Head Start[32] demonstrate that the children in Early Head Start program sites where both home visits and center-based services were offered achieved larger and broader cognitive and language development benefits than children in sites which offered only center-based or only home visiting services.[c] Researchers from Abt Associates[5] have quantified this difference: Family support programs with home visiting services produce gains in cognitive development of .26 of a standard deviation in magnitude, but programs with early childhood education components generate effects almost twice as large (.48).[d]

The National Academy of Sciences concluded, "Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impacts."[33] In other words, parent involvement contributes a unique advantage in center-based early childhood programs.

But, just as important, the conclusion of the National Academy of Sciences suggests that home visiting programs must be coupled with child-focused programs like a good quality child care or preschool program to produce the longest-lasting, broadest range, and largest magnitude changes in children. If that is not possible, perhaps because center-based child care programs are not present in a low-income area or a far-flung rural community, then the home visiting program itself should include extensive, direct, child-focused activities during the home visits in order to promote child development.

V. THE DRIVE FOR QUALITY

Across all the mixed study results, there is one consistent finding: Every home visiting program struggles to deliver high quality services to families. Benefits for children and parents would be stronger and more consistent if program quality were enhanced. Indeed, the National Academy of Sciences has concluded that the key to program effectiveness is "likely to be found in the quality of program implementation…."[34]

Efforts to improve program quality should focus on family engagement, curriculum, home visitors, cultural consonance between program and families served, and delivering appropriate services to high-risk families.

A. Family Engagement

Family engagement encompasses four primary elements: The ability of the program to (1) enroll families, (2) deliver services at the intended level of intensity, (3) retain

[c] These differences fade somewhat in the final, year 3 evaluation results. See Appendix B.
[d] These effect sizes are for programs serving children with and without special needs. As reported in Table 3, the effect sizes are smaller when programs that served children without special needs are excluded.

families in the program, and (4) maintain enthusiastic and active family involvement during home visits and in recommended activities between visits.

Too often, families receive a watered-down version of home visiting services.[2] Up to 40% of families that are invited to enroll in home visiting programs choose not to participate. Acceptance rates are highest (94-98%) in programs that offer a single home visit to all families with newborns or all first-time or teen mothers in a community. Once enrolled, between 20% and 80% of families leave home visiting programs before services are scheduled to end, with typical attrition rates hovering at about 50%. Families who remain in the program typically receive about half the scheduled number of home visits. And, between visits, families do not always do the "homework" that has been assigned to them – and upon which the benefits for children depend. For example, families must read to their children between visits, employ new forms of discipline, or follow up with referrals to other services systems if the hoped-for benefits are to emerge – but research indicates that parents do not always follow the recommendations of their home visitor to change their behavior.

B. The Curriculum

Evidence suggests that benefits are most likely to occur in those program areas that have been emphasized by home visitors in their interactions with families. It is important, therefore, that program planners select a curriculum that directly addresses the goals that have been established for the home visiting program. (See Box 2 for information about selecting curricula.)

Box 2.
Selecting a Home Visiting Curriculum

Program planners should select a curriculum for their home visiting program that directly addresses the goals they have established for the program. National home visiting programs such as PAT, HIPPY, NFP, and PCHP provide a curriculum, but other national programs allow greater flexibility. And, of course, many home visiting programs are developed locally, with program planners often seeking to develop their own curriculum or adopt an existing curriculum.

Researchers from the Center for Prevention & Early Intervention Policy at Florida State University have reviewed curricula for programs that serve expectant families and their infants. Their summary includes information about the intended audience and age range, availability of materials in languages other than English, topics covered, reading level and ease of use, evidence of effectiveness, availability of training and support, and cost.

Graham, M., Chiricos, C., White, B., Clarke, C., et al. Choosing curricula for quality programs serving expectant families & their infants. Florida State University.

But, home visitors can vary greatly in their delivery of the home visit – addressing different content, staying in the home for differing lengths of time – even if they are all trained to deliver the same model. Programs must therefore both (1) employ curricula that clearly address the behaviors associated with a poor outcome (e.g., smoking cessation

during pregnancy to prevent low birth weight; the presence of domestic violence to prevent child maltreatment); and (2) deliver those curricula as intended by the program designers.

C. The Skills and Abilities of the Home Visitors

The success of a home visiting program rides on the shoulders of its home visitors. From the point of view of families, home visitors *are* the program. They draw families to the program, and they deliver the curriculum. Home visitors must have the personal skills to establish rapport with families, the organizational skills to deliver the home visiting curriculum while still responding to family crises that may arise, the problem-solving skills to be able to address issues that families present in the moment when they are presented, and the cognitive skills to do the paperwork that is required. These are not minimal skills, and there is no substitute for them if programs are to be successful.

Hiring the right home visitor is therefore crucial for program success. Unfortunately, research can provide only limited advice on who makes the best home visitors, and most researchers believe it is not possible at this time to conclude that individuals from a particular professional or educational discipline are better home visitors than others.[35,36] However, many of the most recent studies of programs that employed paraprofessionals produced either no or only very modest results,[37,38] and a recent study of the NFP in Denver, Colorado, which directly compared the effectiveness of nurse and paraprofessional home visitors, indicated that paraprofessionals produced benefits of only about half the magnitude of those produced by nurses in outcomes such as deferral of second pregnancies, maternal employment in the second year of the child's life, and mother-infant interaction.[39] (See Appendix B for more details of this study.)

The best advice is to keep in mind the program's goals, the families being served, and the curriculum when choosing a home visitor. Extremely well-trained visitors who are at least high school graduates and have experience in early childhood or the helping professions are probably needed to serve families who are facing multiple, complex issues; or to work in programs with multiple, broad goals or with a curriculum that allows a great deal of flexibility.[36] Paraprofessionals may do best in programs with a relatively proscriptive curriculum, where lesson plans are detailed and clear. (See Box 3 for resources on training materials for home visitors.)

Once they have hired their home visitors, programs must work hard to retain them. Turnover can have a devastating effect on program success rates because it disrupts the rapport and connection between home visitor and parent, and it is that rapport which makes parents more likely to follow the advice of their home visitors. In the NFP in Memphis, for example, turnover among nurses was 50%, and the evaluators suggest that this may be at least part of the reason that results were more limited in Memphis than in Elmira.[21]

Turnover may be a special problem in programs using lower-paid paraprofessionals for whom home visiting may be their first job. HFA and ABC/Cal-SAHF programs in

San Diego and Sacramento have reported turnover rates of about 70% over 18-36 months;[37,40] (See Appendices B and C, respectively, for descriptions of these programs.) A survey of home visiting programs in San Mateo County confirms that turnover is especially an issue among paraprofessional home visitors,[41] and there is some evidence from the Early Head Start program evaluation that low wages, averaging $9.77 per hour in that program, contribute to staff unhappiness.[42]

Box 3. Training Home Visitors

Most of the large home visiting models have prescribed training courses for program coordinators, supervisors, and home visitors. However, communities should consider launching joint training opportunities for home visitors. Barbara Wasik, a professor at the University of North Carolina, Chapel Hill, recommends that all home visitors receive training that covers basic concepts such as the history and philosophy of home visiting, knowledge and skills of the helping process, knowledge of families and children, and knowledge of the community – in addition to the knowledge and skills specific to the particular home visiting program they are delivering. She and her colleagues have catalogued training materials for home visitors. Some of these catalogued materials also include curricula for home visiting programs.

Wasik, B.H. (1993) Staffing issues for home visiting programs. *The Future of Children*, 3(3), 140-157. www.futureofchildren.org

Wasik, B.H., Shaeffer, L., Pohlman, C., & Baird, T. (1996). A guide to written training materials for home visitors. Chapel Hill: The Center for Home Visiting, University of North Carolina at Chapel Hill. www.unc.edu/~uncchv

Wasik, B.H., Thompson, E.A., Shaeffer, L., & Herrmann, S. (1996). A guide to audiovisual training materials for home visitors. Chapel Hill: The Center for Home Visiting, University of North Carolina at Chapel Hill. www.unc.edu/~uncchv

Programs should seek to support home visitors through excellent supervision, a good working environment, and supportive training. A good supervisor is especially important because a good supervisor can help home visitors deal with the emotional stresses of the job, maintain objectivity, prevent drift from program protocols, provide an opportunity for reflection and professional growth, and model the relationship that the home visitor should establish with the parent.[35] Home visiting can be a lonely job, and visitors in small programs may work largely on their own, sometimes without anyone to turn to when problems arise. The best programs build in enough time for the supervisor to meet regularly with the home visitors and to accompany them on occasional visits to families.

D. Cultural Consonance Between the Program and Its Clientele

Parenting practices are strongly bound by culture. Parents of different cultures possess strongly held beliefs about the best approaches to handling sleeping, crying, breastfeeding,[43] discipline,[36] early literacy skills,[44] and obedience and autonomy in children.[36] Further, it appears that the same parenting practices can yield different results for children from different cultures. For example, one recent review suggests that although an authori*tative* parenting style may be associated with more positive outcomes

for white children, a stricter, authori*tarian* style may be associated with more positive outcomes for African-American and Asian-American children.[36]

These differences in parenting practices across cultures may render home visiting programs less effective with some families – if the advice offered by the home visitors is not consonant with the family's beliefs about parenting. In one study, some African-American and Latina mothers characterized home visitor advice as "white people stuff" and ignored it. In the same study, white working class families sometimes questioned home visitors' advice regarding parenting practices, including reading daily to infants.[45]

These different beliefs may be especially important in families in which mothers live with their mothers or extended family. In those families, even if the mother is persuaded that she ought to change an aspect of her behavior, she must also persuade her relatives. Such change can cause strife within the family,[43] and, therefore, some interventions seek to involve grandparents, fathers, or other family members.[46,47] Early Head Start programs, for example, employ a variety of strategies to engage fathers, as described in Box 4.

Box 4.
Strategies to Engage Fathers in Early Head Start

Most home visiting programs focus their services on mothers. But, in many cultures, involvement by fathers and/or by extended family members is critical if programs are to succeed.

Among the 17 Early Head Start (EHS) sites participating in a national evaluation, about 25% had implemented services to involve fathers within the first few years of the program's initiation. The evaluators noted that the programs, "encouraged fathers to participate in regular program services, had staff responsible for working with and involving fathers, offered male support groups, provided recreational activities for men, used a special curriculum for males, or provided other services for males."

By the end of the evaluation, when children were 3 years of age, EHS fathers were more likely to participate in child development activities such as home visits or parenting classes than control fathers, and were less likely to report spanking their children during the previous week (25.4% vs. 35.6%) and were less obtrusive. Their children were more able to engage them during play than were children of control group fathers.

Source: Love, J.M., Kisker, E.E., Ross, C.M., Schochet, P.Z. et al. (June 2001). *Building their futures: How Early Head Start programs are enhancing the lives of infants and toddlers in low-income families.* Vol. 1. Technical report. Department of Health and Human Services, Washington, DC. Available at http://www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

Love, J.M., Kisker, E.E., Ross, C.M., Schochet, P.Z., et al. (June 2002). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start. Executive Summary*. Department of Health and Human Services, Washington, DC. Available at http://www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

There is no clear evidence as to which groups benefit most. For example, in a Salinas Valley PAT project, children of Latina mothers benefited more than other groups on child development outcomes.[48] In interim results for Early Head Start, however, African-American children benefited most, with very few benefits for Hispanics,[49] although both

groups benefited more than white families by the time the study ended.[50] In San Diego's HFA program, white but not African-American or Hispanic women deferred second pregnancies.[37]

The National Academy of Sciences concludes that "…parenting interventions that respond to cultural differences in a dismissive or pejorative manner are likely to precipitate significant conflict or be rejected as unacceptable."[51] This may contribute to high attrition rates.

Because families may withdraw when they hear advice with which they disagree, home visitors may be tempted to refrain from broaching those touchy topics where they know that the program recommends an approach other than the one embraced by the culture of the families they are visiting. While steering clear of controversy may keep families in the program longer, tenure in a program by itself will not lead to benefits for parents or their children. The key is to keep a focus on the specific goals of the program, and to make sure that home visitors find ways to return to that advice, relying upon their relationship with the families to help persuade parents to change their behavior.

The issue of cultural consonance is especially important in multicultural California. All the large home visiting program models have been employed to serve families from many cultures. The California programs profiled in Appendix C, for example, serve white, African-American, Hispanic, Asian American, and Native American families, and immigrants from many nations. Nevertheless, research has yet to catch up with the diversity that is part of the fabric of life in the state, and, while there have been several studies of home visiting with white, African-American, and, to a lesser extent, Hispanic families, there have been far fewer with Asian-Americans or other groups.

Despite the sparse research, programs should institute some minimum standards: While ethnic and racial matching of home visitors to families may not be necessary,[35] home visitors should speak the language of the families they are visiting and should understand their culture, and, especially, their beliefs about parenting, health practices, and the roles of women. To the extent possible, home visitors should involve members of the extended families of the mothers they visit.

E. Developing Services Appropriate for High-Risk Families

As home visiting programs extend their outreach to families at higher levels of risk, they face increasing challenges in developing curricula that can address the needs of those families. For example, HFA uses a screening tool to select higher-need families; NFP only enrolls low-income, first-time pregnant women; and programs drawing their clientele from TANF rolls may find that more and more women have higher levels of need as most women with fewer needs have already entered the workforce. For most programs, therefore, quality services require having curricula and staff in place to serve a high-risk population.

Home visiting programs should be prepared to address three issues which can create especially high risk for children: (1) domestic violence in families; (2) maternal mental health problems, especially depression; and (3) parental substance abuse. Results from many home visiting programs suggest that these issues are among the hardest for home visitors to recognize or to address effectively, and, along with contraception, are the issues that they feel least comfortable discussing.[37,40,52] But, these are precisely the issues that are most likely to stymie progress for parents and to harm children.

For example, about 20% of the general population, as many as 30-40% of the welfare population,[53] and up to 50% of families in some home visiting programs have symptoms of clinical depression.[37,40,52] Every woman enrolled in the HFA program in Lancaster, California had mental health issues upon initial screening.(See Appendix C-2.) Fully 16% of the caseload in an HFA program in Oregon experienced domestic violence just within the first 6 months after enrollment,[54] and 48% of the families experienced domestic violence in the Elmira, New York site of the NFP over a period of 15 years.[22] In the Oregon HFA program, families that experienced domestic violence within the first 6 months of their children's lives were three times more likely to have physical child abuse confirmed than families without domestic violence during that six-month window.[54] Home visiting services must be modified to respond to domestic violence and these other issues. These are sentinel events that have substantial impact on children over the long run.

F. The Malleability of Quality

There is heartening evidence that program quality can be monitored, shaped, and improved. For example, when Healthy Start program administrators in Hawaii discovered that attrition rates varied from 38% to 64% across home visiting agencies, they developed program performance guidelines to govern the time from enrollment to first home visit, home visit frequency, and program attrition. A quick feedback loop in which data on program performance is fed back to program managers is one mechanism by which these variations can begin to be understood and controlled. The Sacramento County Birth and Beyond program has used data in this way, and the NFP has a system in place by which program sites send information to the national offices that then flag for technical assistance those sites where performance is falling below quality thresholds. (See Appendix C-7 and Box 5, respectively.)

When quality improves, outcomes for children improve, too. Early Head Start sites that had early, full implementation of the program's performance standards generated greater benefits in children's development than did sites which had not yet met the standards.[49] In Hawaii's Healthy Start program, program sites that delivered services with the greatest fidelity to the model had the greatest effect on mothers' mental health.[55]

Box 5.
Quality Assurance Strategies in The Nurse-Family Partnership

The Nurse-Family Partnership has a quality assurance system in place that incorporates many of the recommendations listed above. The NFP has specific standards for program performance and requires its program sites to send their performance data to the national office. The national office then reports back to sites to allow them to compare their performance against that of other sites, and against that of sites in which earlier randomized trials indicated significant benefits for children and families. When sites fall below performance benchmarks, the national office offers technical assistance to troubleshoot and problem-solve.

Performance standards in the NFP are based on performance levels observed in program sites, such as Denver, where benefits were observed in children and parents. So, if programs deliver services at levels similar to those achieved in Denver, it is assumed that the programs will also be able to deliver commensurate benefits for children and families.

VI. SUGGESTIONS FOR PROGRAM PLANNERS

The research suggests that home visiting services can play an important role in school readiness efforts, but program planners should maintain realistic expectations about the benefits that home visiting services can produce. The design of home visiting programs should be considered carefully before they are implemented; they should be supported as one of a range of community services for families and young children; considerable effort should be devoted to maintaining program quality and using evaluation data; and individual programs should be coordinated with one another and with other services within their county.

The following are suggestions to local County Commissioners, and to national and local program planners and policymakers who are considering home visiting:

1. Maintain realistic expectations for what home visiting services can accomplish.

Home visiting programs are interventions that have been given large mandates – prevent child abuse; promote school readiness; move families from welfare to work; and more – but no single program is likely to be able to accomplish all those goals. Program planners must maintain realistic expectations for what any single intervention can achieve.

In addition, program planners should be clear about the expectations they have for universal versus targeted home visits, and for limited duration versus intensive home visiting. Most of the research reviewed in this paper focuses on home visiting programs that sought to deliver fairly long-term services to families. Communities such as Alameda County and Cuyahoga County in Ohio, however, have begun to offer an initial home visit to most or all families within their community, no matter the income level of the families (see Appendix D). These visits tend to be extremely popular and well-received. In Cuyahoga County, they result in as many as 25% of

the visited families being referred on to additional services. But, the long-term effectiveness of these widely-offered services in either identifying families earlier, engaging them more closely with service systems, or promoting their children's school readiness has not yet been demonstrated. (See Appendix E (FAQ7): Should We Target Services to Particular Groups or Offer Them Universally?)

2. Make each funded home visiting program a strong, high quality program.

Program planners and administrators, and individual program sites should take steps to ensure quality services.

a. Program funders and funding agencies, including local First Five Commissions should:

(1) Before launching a program, consider carefully the role that home visiting is likely to play in promoting school readiness.

There are many service strategies available to promote various aspects of school readiness. Before endorsing home visiting, local funders should consider the specific goals that they hope the proposed home visiting program will accomplish, and the community context. If they are especially interested in cognitive development, for example, they might consider a center-based, child-focused service strategy instead of or in addition to home visiting. If their community is a far-flung rural area, or one in which most families prefer informal child care, then center-based programs may not be feasible, and home visiting can be considered as a strategy to promote cognitive development, so long as it has a strong, child-focused component. (See Appendix E (FAQ1): Should We Launch A Home Visiting Program to Promote School Readiness?)

(2) Select a program model whose curriculum clearly addresses the goals targeted by the county.

Research indicates that programs typically can only accomplish those goals on which their home visitors focus, and so it is important to select a program whose goals and curriculum match the goals of the community. Some programs (e.g., HIPPY, PAT, and PCHP) may focus most on child development and early literacy activities. Others (e.g., HFA) may focus most on the prevention of child abuse and neglect and the promotion of good parenting. Some programs (e.g., NFP, HFA, and EHS) include explicit attention to family economic self-sufficiency, whereas others refer families to other community services for assistance in those arenas.

Having a deep understanding of the curriculum is especially important when choosing among home visiting programs that have multiple goals (as almost all do). Because home visitors usually are able to complete only

about half their visits, it is important to understand which parts of the curriculum are considered to be of core importance to the program, because those are the messages that will be most likely to be conveyed to families. (See Appendix E (FAQ2): Which Home Visiting Model Should Be Selected?)

(3) Consider carefully which agency will administer the proposed home visiting program.

Administering agencies possess philosophies about what families need and how they should be served, and they bring their history in the community, familiarity with particular content areas and the staff associated with those areas, and, in some cases, complementary services. All of these can affect the content and services that families eventually receive during the home visit and between visits. For example, the same program delivered by a home visitor who is a social worker will have a different slant when it is delivered by an individual with an early childhood background. The Birth & Beyond home visiting program in Sacramento reports that families may be more likely to welcome home visits from agencies that have a long history in the community. Different administering agencies may have, as they did in Hawaii's Healthy Start program, different philosophies about how hard to work to try to engage families – which may influence attrition from the program. A recent evaluation of PAT suggested that families benefited most when home visits were delivered by an agency with a rich array of complementary services which families could access easily. These should all be considerations of funders before they support the expansion of home visiting services. (See Appendix E (FAQ3): Does Who Administers the Program Make a Difference?)

(4) Support the costs of program monitoring and quality improvement, including data collection, MIS development, data analysis and feedback to program sites.

Typical home visiting programs cost between $1,500 - $5,000 per family per year. Fully 80% of the program costs are direct costs for personnel. While program monitoring and quality improvement costs may not encompass a large percentage of the budget, an attention to quality and a commitment to paying for the tools that are necessary to maintain quality are imperative if home visiting services are to benefit families. (See Appendix E (FAQ8): How Much Does Home Visiting Cost, and How Can We Pay for Services?)

(5) Facilitate the development of common definitions for key program quality components (e.g., terms such as enrollment, attrition, missed visit, reasons for exit, paraprofessional) among funded programs.

Different program models, and sometimes different sites of the same program model, employ different definitions of important terms. For example, some programs define a family as enrolled when the mother first gives her consent to participate in a home visiting program. Others say the family is enrolled after the first home visit is completed, after the first three visits are completed, or after the Individual Family Service Plan is completed. Similar variability occurs in the definition of attrition. Clearly, these differing definitions can create very different pictures of the performance levels in any one program. Funders can facilitate the process of developing clear, common definitions that can be used by all home visiting programs in their community.

(6) Require reporting around key program quality components, using common definitions if they have been developed, or asking programs to include their definitions if common definitions are not yet developed.

(7) Support the use of techniques of continuous quality improvement similar to those used in business. Support rapid improvement cycles, in which new strategies to address quality problems are tried out for a few months, data are collected to monitor their effects, and, if successful, the new approaches are implemented. If the strategies are not successful, then other approaches are tried. These might include new strategies to retain families, new approaches to recruiting families to the program, new training for program staff to focus on particular aspects of the curriculum, and so on.

b. Individual program sites should:

(1) Make sure that they adhere to program standards established by the national headquarters for their program model.

If programs are not affiliated with a national model, then they should make sure that they establish standards for the key components of program quality. The performance standards should address issues of engagement (including enrollment, service frequency, attrition rates, and involvement of families in complementary services such as parent group meetings); staff background, training, caseloads, and supervision levels; cultural consonance; and addressing families with special needs. Developing clear definitions for terms related to engagement are especially important because these terms are used very differently across models and program sites.

If national offices have not yet established performance standards, local program planners and funders should urge them to do so, and they should consider seriously selecting another model that has such standards in place.

(2) Hire, train, and retain the best home visitors available.

Home visitors are the keys to program effectiveness. Programs should work to hire, train, and support the best home visitors they can find. In their

relationships with home visitors, site managers should model the relationships that home visitors should establish with the families they serve. Home visitors should receive training about home visiting in general as well as about the specific model of home visiting that they are being hired to deliver. And, special efforts should be devoted to making sure that home visitors understand, endorse, and are able to implement the specific home visiting curriculum associated with the selected model. Just as the families they visit have views about parenting which they bring to any home visit, so too do home visitors, and it is imperative that the visitors understand and believe in the goals of the program that they are being hired to implement – including views about discipline, family planning (if that is part of the program), and other sensitive family matters. (See Appendix E (FAQ6): Whom Should We Hire as Home Visitors?)

(3) Monitor performance on program standards regularly and provide feedback to staff.

(4) Seek out opportunities for cross-site comparisons on performance standards, and for follow-up learning to figure out what contributes to the varying performance at each site. Table 4 in Appendix A summarizes the attrition rates from recent studies of several home visiting programs. A similar comparative chart could be developed for almost every aspect of program performance. With the assistance of funders, program staff could travel to their partner sites to learn from one another how their performance could be improved.

(5) Within a site, use techniques of continuous quality improvement and rapid improvement cycles.

(6) To make sure that services are culturally appropriate, home visitors should, at the very least, speak the primary languages of the families they serve, and handouts should be in the primary languages of the families. Of equal importance, home visitors should have a deep understanding of the culture of the families they visit, and, especially, of their beliefs about parenting, health practices, and the roles of women. To the extent possible, home visitors should involve members of the extended families of the mothers they visit.

3. Coordinate home visiting services and resources within each county.

Coordination should make home visiting services easier for families to access and less expensive to deliver.

a. Before launching a new home visiting program, county First 5 Commissions should sponsor a survey of existing home visiting programs.

Several counties (e.g., San Mateo, Orange, Los Angeles, and Riverside) have conducted surveys of home visiting programs in their counties. Such surveys can identify what home visiting models are in place, who they serve, their geographic cachement areas, how they get referrals to their programs, and the main goals of their services. This can identify geographic areas and families that are underserved, as well as opportunities for a more rational approach to referrals or service delivery. (See Box 6 for information about some of these surveys.)

b. Coordinate referrals to home visiting programs.

Within a county, different home visiting programs may excel at serving particular types of families or addressing particular goals. Counties may consider a centralized intake and referral system, such as the system that exists in Cuyahoga County in Ohio (See Appendix D), to assign families to home visiting agencies depending upon their initial needs.

In addition, county planning commissions should consider if it is possible to restrict the number of home visitors any one family might receive. Anecdotes abound concerning families who are being visited by five or ten home visitors – each from a different social service program. It is hard to see how this can be anything but a burden to families.

c. Coordinate messages across home visiting programs and across other service programs within the community.

Parents are faced with multiple messages about parenting and child development each day, beginning with what they hear from their own families and including what they learn from home visitors, child care providers, parent education workshops, and so on. The messages from any one program will be much more powerful if they are echoed in other programs. County First 5 Commissions should consider the possibility of supporting programs that adopt similar curricula across settings (e.g., a similar child development curriculum adopted by both a network of family child care homes and by a local home visiting program).

d. Require common definitions and terminology in reports on home visiting services from all county-funded agencies and organizations.

Common definitions will increase the ability of local commissions to make comparisons on program performance in subsequent years.

Box 6.
Planning for a Countywide Home Visiting Program:
Countywide Surveys

Some counties have commissioned surveys to describe all the home visiting programs operating within the county. These surveys vary, but typically are designed to determine where and under which administrative auspices the programs operate, their goals, and the families served. Such surveys can illuminate areas of redundancy as well as need, and opportunities for joint training, recruitment of families, and information sharing. Anecdotal reports continually surface of some families receiving visits from multiple home visitors, each with a slightly different focus. If communities could coordinate visits and the messages delivered to families, each intervention could become more powerful.

Orange County

O'Brien-Strain, M., & Gera, J. (August 16, 2001) *Home visitation programs in Orange County*. Available at www.sphereinstitute.org.

Researchers from the Burlingame, California SPHERE Institute surveyed home visiting programs in Orange County. The survey identified 17 home visiting programs, administered by 8 different agencies. The following information is captured for each program: Primary goals, home services, other services, target population, caseload per home visitor and annual caseload, staff credentials, scheduled duration and frequency of services, and the logic model for each program. The report also maps the outcomes hypothesized by the home visiting programs against the outcome indicators identified in the Orange County Children and Families Commission framework. The same researchers are undertaking a survey of Riverside County home visiting programs.

San Mateo County

Goodban, N. (2001). *Like a "segunda mama": Home visiting services for young children and their families in San Mateo County*. Report commissioned by the Peninsula Partnership for Children, Youth and Families. Available from the Peninsula Partnership web site (www.pcf.org) or by calling Peninsula Partnership at 650-358-9369.

This report includes a description of the 23 home visiting programs in operation in San Mateo County as well as results of structured interviews with program staff, focus groups with parents, and key informant interviews with local experts. Results are put into context with existing literature on home visiting. Best practices are identified and recommendations are made concerning access, best practices, service integration, and staffing.

The following information is listed for each program: mission, goals, target population, geographic area, year the program began, referral process, staffing/supervision, the program's theoretical or research justification, program components, collaborative partners, major challenges, performance measures, outcomes, evaluation, budget and funding sources, staff, new children/families annual, caseload, average/median time families spend in the program, number of home visits per month, desired and actual caseload.

As of February 2002, the study author reported that the recommendations were slated for review, prioritization, and, hopefully, implementation in coming months.

e. Coordinate the training of home visitors to save resources, build camaraderie, and help programs learn from one another.

Although each home visiting program has its own curriculum and will require some specific training, home visitors can all benefit from some core training about child development, parenting, family dynamics, the process of building

rapport with families, and so on. County First 5 Commissions could explore supporting joint training to help build the experience of home visitors and, perhaps, consolidate some of the expenses associated with training. In Sacramento County, for example, efforts are beginning to develop courses, perhaps in conjunction with community colleges, that will build a career path for home visitors. Just as in the child care field, such an effort might both develop the skills of home visitors as well as provide a path for their professional development – which could lead to lower rates of staff turnover.

4. Embed home visiting services in a system that employs multiple service strategies, focused both on parents and children.

Considerable evidence exists that, while parent involvement confers some unique advantages, such parent involvement does not lead to as large effects on children's cognitive development as do high-quality, center-based, child-focused services. In addition, home visiting is not the only route to achieve parent involvement. Therefore, program planners should:

a. Create a strong system of services that includes health insurance coverage, child-focused child development services, and home visiting, so as to improve parenting and promote child health and development.

Health insurance and access to health services. Home visiting programs often seek to make sure that children have a medical home or that they receive appropriate preventive health services, but randomized trials suggest that home-visited families usually do not show benefits over control groups. For families who have no health insurance, or who must take several buses to reach a doctor, even the best home visiting program's referral to a doctor will not translate into their children receiving appropriate health services. Communities should therefore focus on implementing the policies that will eliminate financial barriers to health care (e.g., health insurance) and/or consider the benefits of a close connection with a medical center or clinic. The Early Childhood Initiative in Cuyahoga County, Ohio (Appendix D) illustrates an initiative that encompasses a strong health insurance component that has successfully enrolled 98% of eligible birth- to 5-year-olds in health insurance. The Parent Child Home Program, administered by the Los Angeles Eisner Pediatric and Medical Center, is an example of a home visiting program that is administered by an agency that provides health care services. (Appendix C-6)

Center-based early childhood development. Home visiting services tend to focus on the parents and to encourage parents to change their behavior so as to create change in children. They deliver many fewer hours of contact with children than do center-based child care, preschool, or other early childhood programs. Together, these facts may help explain why home visiting programs more often produce benefits in outcomes related to parents and parenting behaviors than they do in outcomes associated with children.

Home visiting. Home visiting services or other services designed to increase parent involvement in their children's lives do confer benefits, and so they should be part of a community's system of services.

b. Include services that are focused both on parents and on children.

Many programs struggle to deliver child-focused child development services when parents have obvious needs for employment, social support, or material assistance. But, there is considerable evidence that programs achieve those goals on which they focus, and that children's development is not improved as much through a program in which the primary focus is on the parents as it is in a program in which the primary focus is on the child's own development.

Communities should therefore offer services that provide dedicated time and attention to both parents and their children. (See Appendix E (FAQ4): Should Programs Focus on Just a Few Goals or Should They Be Broad and Comprehensive?)

c. Offer multiple approaches for parent-focused services.

As many as 40% of those parents who are invited to enroll in home visiting services decline to participate. About half the families leave home visiting programs before services are scheduled to end. Those parents decline participation for a variety of reasons, but at least some of them might prefer a different service approach. Indeed, research suggests that programs that offer both home visits and parent groups attract somewhat different participants to each – and that parent groups can sometimes be more effective than home visiting.

Strategies other than home visiting that can be parent-focused include parent support groups, parent education workshops, Mommy and Me playgroups, and family resource centers. The goal within a community should be to increase the support afforded parents in their roles as parents – whether that support is derived through home visiting or some other service strategy.

d. Consult with families regularly to make sure that the mix of services is appropriate.

As in any business, client use of services reveals the clients' valuation of those services. Every home visiting program should solicit regular input from families to make sure that the service mix is balanced correctly, that families value the services offered, and that the reasons that families leave the programs are understood, and, if feasible, addressed. Programs should employ strategies, such as routine surveys, interviews, or focus groups with parents, to gather the opinions of the families they serve.

VII. CONCLUSIONS

Home visiting services can produce the results that prepare children for school, but they do not always do so in practice. And, benefits are often small. When averaged across program models, sites, and families, results for most outcomes are about .1 or .2 of a standard deviation in size, an effect size that is considered small in human services. Effects are most consistent for outcomes related to parenting, including the prevention of child abuse and neglect (depending upon how child maltreatment is measured). Home visiting programs do not generate consistent benefits in child development or in improving the course of mothers' lives. Families in which children have obvious risk factors (e.g., they are biologically at-risk, developmentally delayed, or they already have behavior problems) appear to benefit most. Some studies also suggest that the highest-risk mothers (e.g., low income teen mothers; mothers with poor coping skills, low IQs, and mental health problems) may benefit most, but probably only if the program offers services tailored to address the needs of these mothers.

For every outcome, as many as half of the studies and programs demonstrate extremely small or no benefits at all. But, for every outcome, a few programs or program sites demonstrate larger benefits, and it is those more positive results which have driven the expansion of home visiting programs and which illustrate the *potential* of home visiting.

The mixed and modest results, however, illustrate just how fragile an intervention home visiting can be. The most intensive national models are slated to bring about 100 hours of intervention into the lives of families. More typically, programs deliver perhaps 20 or 40 hours of intervention over the course of a few years. That is not much time in which to address issues as complex as child abuse and neglect, school readiness, and deferral of second pregnancies. But, that is the task that has been set for home visiting programs. It is therefore important for policymakers and practitioners to keep their expectations modest about what can be accomplished through any single intervention.

Nevertheless, high quality home visiting programs can play a part in helping prepare children for school and for life. Together with other services such as center-based early childhood education, joint parent-child activities, and parent groups, home visiting can produce meaningful benefits for children and families. For that reason, home visiting services should be embedded in a system that employs multiple service strategies, focused both on parents and children.

Even in such a system, the key to effectiveness is quality of services. Only the best home visiting programs have a chance to benefit children and parents, and funders and program administrators must strive to make each funded home visiting program a strong, high quality program.

To be effective, programs must focus on the goals that they seek to accomplish and make sure that their curricula match those goals, that their staffs are in sync with the

goals, and that the families they serve receive information and assistance related to those goals. Programs must seek to enroll, engage, and retain families with services delivered at an intensity level that is as close to the standards for their program model as possible. They should hire the best, most qualified staff they can, and pay them wages that will encourage them to stay. They should seek the counsel of their clients to make sure that they are offering services that their customers want and need. The good news is that quality is malleable, and that programs that set performance standards, monitor their progress toward achieving them, and make corrections along the way are much more likely to produce benefits.

Finally, funders and administrators should consider home visiting services from the point of view of parents and children. To that end, home visiting services should be coordinated within each community so that families receive referrals to the home visiting program that best meets their needs, home visiting programs share training and resources, and families are not faced with multiple visitors.

Home visiting services have the potential to build school readiness for children. They are best delivered as one of a range of community services offered to families with young children. They are not a silver bullet for all that ails families and children, but then no single program or services strategy can be. When done well, home visiting services recognize and honor the special role that parents play in shaping the lives of their children, and they can help create ready families and communities, ready children, and ready schools.

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Deanna S. Gomby, Ph.D., M.S.
Deanna Gomby Consulting
903 Sunrose Terrace, #206
Sunnyvale, California 94086
(408) 736-8450

eleganttern@earthlink.net

APPENDIX A
BUILDING SCHOOL READINESS THROUGH HOME VISITATION: DETAILED RESEARCH FINDINGS

CONTENTS

I. INTRODUCTION

This Appendix is the detailed literature review that forms the basis for the findings that are summarized in the main paper. Appendix A addresses questions often posed about home visiting – questions such as, do home visiting programs help produce "ready children," "ready families and communities," and "ready schools?" Which families benefit most? How should home visiting programs be structured to maximize effectiveness? What can be done to promote the quality of program services?

Appendix A begins with background information on the major home visiting programs and the rationale for their use to promote school readiness, and then summarizes research findings in three main areas:

- School readiness outcomes when home visiting is the main program strategy;
- School readiness outcomes when home visiting is coupled with other service strategies; and
- Program quality.

II. HOME VISITATION SERVICES AND THE RATIONALE FOR THEIR USE TO PROMOTE SCHOOL READINESS

Home visiting is the name given to many service programs that share a single strategy: sending individuals into the homes of families or individuals to deliver services. Home visiting programs can serve the young as well as the elderly, and children with special needs and those without. They can provide a single visit to new mothers discharged early from the hospital, as well as multiple visits over several years to promote long-term change in families. And, they can provide primary prevention to broad groups of families as well as treatment for specific families with identified problems.

In this paper, however, the focus is on a subset of home visiting programs – those that send individuals into the homes of families with young children and seek to improve the lives of the children by encouraging change in the attitudes, knowledge, and/or behaviors of the parents. These are primary prevention programs, beginning prenatally or soon after birth, and continuing for as long as the first 3 or 5 years of the child's life. These programs include nationally known models such as Early Head Start, Healthy

Families America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), the Nurse-Family Partnership (NFP), Parents as Teachers (PAT), and the Parent-Child Home Program (PCHP). Together, these programs have thousands of sites across the nation, and each is in use in California.

These national models are the home visiting programs whose goals are most closely aligned with the school readiness focus of the First 5 California. They typically seek to:

- Promote enhanced parent knowledge, attitudes, or behavior related to childrearing;
- Promote children's health;
- Promote children's early learning and development;
- Prevent child abuse and neglect; and/or
- Enhance mothers' lives (e.g., decrease stress, provide social support, decrease rates of subsequent births and tenure on welfare rolls, and increase employment and education).

These goals are closely linked to the definition of school readiness adopted by the First 5 California Children and Families Commission. In other words, if home visiting programs are successful in achieving their goals, children will be much better prepared for school and for life.

III. WHAT DO HOME VISITATION PROGRAMS HAVE IN COMMON? HOW DO THEY DIFFER?

Home visiting programs differ, but they also share some common elements. The most important among these is that the success of home visiting depends upon the relationship between home visitor and parent. The ways in which programs are structured and delivered are important influences on that relationship.

A. Common Characteristics in Home Visiting Programs

The success of home visiting depends upon the relationship between home visitor and parent.

Most home visiting programs seek to create change by providing parents with (1) social support; (2) practical assistance, often in the form of case management that links families with other community services; and (3) education about parenting or child development.[1] The social support and practical assistance help to engage families and to build a relationship of trust between home visitor and parent. A strong relationship, in turn, can help reassure parents as they undertake the difficult work of acting upon the information and education provided by the program. Some researchers and practitioners also believe that, for some parents, creating a trusting relationship between home visitor and parent can be a first

step in developing the parent's ability to form and sustain secure relationships with others, including with her own children.[2,3] If the home visitor-parent relationship is weak, then benefits for parents or children are much less likely. Many of the ways in which programs differ influence the capacity of the program to establish that home visitor-parent relationship.

B. Differences Among Home Visiting Programs

Home visiting programs differ in their specific goals; in the level of the services they offer; in their staffing; and in whom they serve. Table 1 compares some of the largest national models of home visiting on these key dimensions. Appendix C provides more detailed information about each model, including its presence in California.

1. *Goals*

Most of the large home visiting program models focus on improving parenting skills to promote healthy child development and to prevent child abuse and neglect. Some explicitly seek to improve the lives of parents by encouraging mothers to return to school, find a job, or defer subsequent pregnancies.

2. *Intensity of Services*

Programs also differ in the onset, duration, and intensity of their services. Some programs begin during pregnancy, while others begin at birth or later. Programs are slated to last from two to five years, and visits are scheduled from weekly to monthly. If visits are limited or too infrequent, it may be difficult to establish a close home visitor-parent relationship.

3. *Staffing*

The experience and training requirements for home visitors also vary. Some programs primarily employ paraprofessionals, typically individuals from the community being served. These visitors generally have little formal education or training beyond that provided by the program, but, because their backgrounds are similar to the backgrounds of the parents, they may be able to more easily form a rapport with the parents. Others employ a variety of home visitors, including some paraprofessionals and others who have bachelors and masters' degrees. Some require particular types of professionals, such as nurses.

4. *Whom They Serve*

Programs also vary in terms of the populations that they serve. Some programs screen a wide number of families at the birth of a child but enroll only those families identified as highly stressed or at-risk for potential child abuse; others seek to enroll all or most of the families who live in the geographic catchment area for the program.

TABLE 1. DESCRIPTIONS OF KEY NATIONAL HOME VISITING PROGRAM MODELS (as of February 2002)

	Program Goals	Onset, Duration, and Frequency of Home Visits	Population Served	Background of Home Visitors	Training Requirements for Home Visitors
Early Head Start 664 sites nationally 53 sites in California	• Promote healthy prenatal outcomes for pregnant women • Enhance the development of very young children • Promote healthy family functioning	For home-based Early Head Start model only: Birth through age 3 Weekly home visits	Low-income pregnant women and families with infants and toddlers; 10% of children may be from families with higher incomes; 10% of program spaces reserved for children with disabilities	No specific requirements, although infant and toddler backgrounds preferred	Vary by program. Staff development plans and ongoing professional development required.
Healthy Families America 450 sites nationally 2 sites in California	• Promote positive parenting • Prevent child abuse and neglect.	Birth through 5th birthday Weekly, fading to quarterly	Parents in the mainland U.S. and Canada, all income levels and ethnicities, who are identified at the time of birth as at-risk for abuse and neglect	Paraprofessionals and Bachelor degrees	One week of pre-service training; 1 day of continuing training quarterly; 80 hours of additional training in the first 6 months of service are recommended by Prevent Child Abuse America.
The Home Instruction Program for Preschool Youngsters (HIPPY) 160 sites nationally 11 sites in California	• Empower parents as primary educators of their children • Foster parent involvement in school and community life • Maximize children's chances for successful early school experiences	Academic year, or two years before, and through the end of kindergarten Bi-weekly, i.e., at least 15 times, over 30 weeks during the school year	Families in the United States and Guam; all ethnicities; many low-income and with limited formal education.	Paraprofessionals, typically members of the community and former HIPPY parents. Most work part-time (20-25 hours/week)	Two-day pre-service training in the HIPPY program model, plus weekly ongoing training and staff development.

	Program goals	Onset and duration	Population served	Background of home visitors	Training requirements for home visitors
The Nurse-Family Partnership 250 sites nationally 11 sites in California (1 to open Fall 2002)	• Improve pregnancy outcomes • Improve child health and development • Improve families' economic self-sufficiency	Prenatal through 2nd birthday Weekly, fading to monthly	Low-income, first time mothers, all ethnicities	Public health nurses	Two weeks of training in the program model over the first year of service. Forty-six hours of continuing education in assessing parent-infant interaction, plus additional continuing education as needed.
The Parent-Child Home Program 132 sites nationally 4 sites in California (1 to open Fall 2002)	• Develop children's language and literacy skills • Empower parents to be their children's first and most important teachers • Prepare children to enter school ready to learn • Enhance parenting skills • Prepare children for long-term academic success and parents to be their children's lifelong academic advocates	Typically 2nd through 4th birthdays, but as young as 16 months (two years total) Two visits/week	Families in the United States, Canada, Bermuda, and the Netherlands; low-income, low-education families; all ethnicities; families with English as a Second Language; teen parents; homeless families	Paid paraprofessionals from the community, many previously parents in the program. Small number of volunteers, who may be professional.	16 hours of training prior to becoming a home visitor. Weekly minimum two-hour ongoing training and supervision session.
Parents As Teachers 2,879 sites nationally 88 sites in California	• Empower parents to give their child the best possible start in life • Give children a solid foundation for school success • Prevent and reduce child abuse • Increase parents' feelings of competence and confidence; • Develop home-school-community partnerships on behalf of children	Prenatal through 3rd birthday; may extend through 5th birthday Monthly, biweekly, or weekly, depending upon family needs and funding levels	Families in the United States and six other countries, all income levels and ethnicities.	Paraprofessionals, and AA, Bachelor, and advanced degrees	One week of pre-service training, 10-20 hours of in-service training, annual credentialing by the Parents As Teachers National Center

NOTE: As of January 2003, Parents as Teachers had 109 sites in California and Early Head Start had 51.
SOURCE: National program offices and the websites for each home visiting model. See Appendix C for additional details, including contact information.

IV. DO HOME VISITATION PROGRAMS BUILD SCHOOL READINESS?

Results vary widely across program goals, program models, different sites implementing the same model, and different families within a single site. A recent meta-analysis by Abt Associates of family support programs evaluated since 1965, most of which relied on home visiting as an intervention strategy, found that over half of the studies reported very small or no effects.[4]

But, the popularity of home visiting has been driven by a few studies in which effects were much larger. The following sections therefore describe both the "best cases" – those studies which have captured the attention of policymakers and practitioners with large results – as well as the more typical findings.

Findings are presented below, grouped into the three major areas of school readiness identified by the First 5 California Children and Families Commission: (1) Ready Families and Communities; (2) Ready Children; and (3) Ready Schools. Generally, results suggest that programs are more likely to produce benefits in outcomes related to families (i.e., in aspects of parenting and, perhaps, prevention of child abuse and neglect), than in outcomes related to children (i.e., children's health or development).

The studies that form the basis of this review are evaluations of programs in which home visiting has been the primary service strategy. A subsequent section of this paper examines the effects of home visiting services when they are offered in conjunction with other services.

A. Ready Families and Communities

The First 5 California Children and Families Commission defines "Ready Families and Communities" as follows:

> Family and community supports and services that contribute to children's readiness for school success
>
> - Access to high-quality and developmentally appropriate early care and education experiences
> - Access by parents to training and support that allows parents to be their child's first teacher and promotes healthy functioning families
> - Prenatal care, nutrition, physical activity, and health care that children need to arrive at school with healthy minds and bodies and to maintain mental alertness[5]

The home visiting programs highlighted in this Appendix all seek to provide training and support for parents, and many also seek to promote good child health. Results of evaluations of these and similar home visiting programs suggest that many programs lead

to small increases in parents' knowledge of child development or improvements in parents' attitudes about parenting, and some are associated with changes in parent-child interaction or the prevention of child abuse and neglect. Changes in the home environment – either to make it safer or more likely to promote early literacy or child development – are more rare. When tested with rigorous methods, most home visiting programs have not increased the utilization of preventive health care or led to benefits in children's health status.

1. Parenting Knowledge, Attitudes, and Behavior

Many home visiting programs seek to change parents' knowledge of child development, their attitudes toward parenting, or their view of themselves as parents – all assumed to be necessary first steps toward enhancing the parent-child relationship, reducing rates of child abuse and neglect, and promoting children's health and development. Parents who have an accurate understanding of children's development will react with understanding and good humor rather than frustration or abuse if their young child cannot accomplish what an older child might. Parents who feel confident in their ability to be parents, who are less stressed, and who know a variety of ways to discipline their children will be warmer and more responsive to their children and less likely to resort to harsh discipline or physical violence. Children will develop better when there are more books and developmentally stimulating toys in the home and when parents talk with their children more and respond more quickly to them. Programs also often assume a cascading set of reactions: Once parents begin to respond with warmth and nurturance to their children, the children begin to respond differently to their parents. They may become more attached, and that new close bond can become so rewarding to parents that they will spend more time nurturing their children, which should continue to make the interactions between parent and child more beneficial for both. That close bond, and the hoped-for decreases in abuse and greater success in school, might all lead children later in life to avoid delinquent or other maladaptive behavior.

Many home visiting programs show consistent, though small, benefits in outcomes associated with parenting.

These benefits can be measured directly, by impartial observers of the mother-child relationship, and/or indirectly, by mothers' reports of their own behavior or attitudes. Several home visiting programs have demonstrated benefits on one or more of these measures. Indeed, many home visiting programs show consistent, though small, benefits in outcomes associated with parenting.

A recent review of several evaluations of the Healthy Families America (HFA) program, for example, concluded that the "most robust" effects of that program are found in areas related to parent-child interaction and parental capacity.[6] Interim results of a large national evaluation of the effects of Early Head Start services demonstrated improvements in a whole range of parenting knowledge, attitudes, and behaviors, including changes in parent-child interactions and in the literacy-supporting nature of the home. Similar to other home visiting programs, the effect size of EHS was less than .10-.15 of a standard deviation for most outcomes,[7] generally considered by social scientists

to be too small to be clinically significant.[8] (See Box 1 for a discussion of the definition and interpretation of effect sizes.) However, the Early Head Start researchers concluded that the fairly consistent pattern of effects suggests that services *are* having a meaningful impact on children and families – an impact that will lead to broader and larger effects on children in later years.

In several studies, differences on self-report scales designed to assess parental attitudes or behavior are found more often than are differences on measures of the home environment or observed mother-child interaction. For example, parents in Hawaii's Healthy Start program, which was the forerunner of the Healthy Families America program, reported experiencing less stress than members of the control group, less frequent use of harsh discipline, and a greater sense of efficacy as parents, but independent observers saw no notable differences in the mother-child relationship.[9]

The Abt Associates meta-analysis concludes that family support programs (which include both home visiting, center-based, and parent group approaches that have a parent education component) collectively yield benefits in parenting attitudes, knowledge, and behavior of about .18-.25 of a standard deviation, but the largest effects are generated by programs that use parent support groups rather than home visiting services.[4] In addition, the Abt researchers suggest that the largest effects on parent behavior are seen in those programs that focus on families where children are already identified with behavior problems, rather than those programs that seek to promote good child rearing practices for a general population. They judge the effects for family support programs so small that, "It is not clear whether a difference of this size represents a change that is large enough to have the effect on children's well-being that it is ultimately intended to bring about."[10]

University of California at San Diego researchers conducted another meta-analysis, this one focusing on just the subset of studies in the Abt database that employed home visiting. They too concluded that home visiting produces small benefits in parenting attitudes (.10 of a standard deviation) and parenting behavior (.09 of a standard deviation)[11] – in other words, about what was observed in the Early Head Start study.

In sum, the results suggest that home visiting programs may produce changes in the precursor parenting attitudes, and sometimes the parenting behaviors, that are related to prevention of abuse and neglect and promotion of healthy child development and school readiness. Effect sizes of less than .20 of a standard deviation appear to be the norm, and families that seek out services because they are trying to address an identified problem may benefit most.

Box 1.
Statistical Significance and Effect Sizes:
When is a Result Large Enough to Be Important?

In good program evaluations, researchers compare families that received a service such as home visiting with families that did not, and then use statistical tests to assess whether the results are truly due to the intervention (e.g., home visiting) and not just to chance. If the difference between the two groups exceeds agreed-upon standards, then the results are called "**statistically significant**," and deemed likely to be obtained again if the study were repeated. Sometimes, very small differences between groups (e.g., one or two points on a standardized test) can be statistically significant, even though such differences may not have any practical or functional importance for the families.

To assess if a difference is large enough to be important in a real-world sense, researchers calculate an "**effect size**," which translates the difference between two groups into standardized units. Rules-of-thumb, used in the field of human services for many years, define effect sizes up to .20 as small, .50 as moderate, and .80 as large, measured in standard deviation units.

Home visiting programs typically produce effect sizes that would be judged under these rules to be too small to be meaningful. But, even small effects sometimes can be important. The effect size of aspirin in reducing heart attacks is only .03, but many physicians recommend that their patients take aspirin daily. The effect size of psychotherapy is about .32, but many people regularly see psychologists and psychiatrists (McCartney & Dearing, 2002).

Examples like these suggest that even a small change can be important if:

- it can be produced across a whole population,
- it is closely connected with a very significant event or outcome, and
- the intervention is relatively inexpensive to deliver.

This is the case for aspirin and heart attacks: an aspirin-a-day is a very inexpensive intervention, and the benefits that can be achieved if all adults participated would be enormous in terms of health, happiness, and reduced costs for the country.

If, on the other hand, a relatively expensive program produces only a small effect size on a paper-and-pencil test that does not predict actual behavior of parents or children, then the program may not be worth replicating. In other words, it is more important that home visiting programs produce even small benefits on actual changes in parenting behavior, child abuse and neglect, or children's school performance, than that they produce benefits on paper-and-pencil tests that may not predict real outcomes for children and parents.

Implications for Program Planners:

- Ask program evaluators to calculate effect sizes in addition to tests of statistical significance.
- If evaluations use paper-and-pencil measures, make sure the measures actually predict behavior change in children or parents.
- Try to include assessments of real behavior in addition to any paper-and-pencil measures.

For further information about effect sizes:

McCartney, K., & Dearing, E. (Winter 2002). Evaluating effect sizes in the policy arena. *Evaluation Exchange, 7(*1). Cambridge, MA: Harvard Family Research Project.

McCartney, K., & Rosenthal, R. (2000). Effect size, practical importance, and social policy for children. *Child Development, 71*(1), 173-180.

2. Child Health and Safety

Many home visiting programs seek to ensure children's good health by promoting the utilization of preventive health services such as prenatal care, immunizations, or well-baby check-ups. Some programs use parent education to teach parents the value of preventive health services; others may provide medical care directly. Home visitors may also focus on safety issues, including both the removal of safety hazards in the home and the prevention of child maltreatment. Improved birth outcomes and good child health are important both in their own right, and also because good health is an essential building block for children's general development. Elimination of child abuse and neglect is important for children's physical and emotional health.

Generally, results suggest that home visiting programs are not associated with increases in utilization of preventive health care services or in broad measures of child health status, but they can prevent injuries and, perhaps, child abuse and neglect.

a. Nutrition: Breastfeeding and Diet

Good health for children is heavily influenced by good nutrition, and many home visiting programs seek to encourage breastfeeding and healthy diets. Breastfeeding, in particular, can help protect children from early infections which can hamper their development. At the Memphis, Tennessee, site of the Nurse-Family Partnership, for example, mothers who had been visited by a nurse home visitor were more likely to attempt breastfeeding than their control group counterparts (26% versus 16%), although the groups did not differ in duration of breastfeeding.[12]

Few studies have actually assessed the effects of home visiting on these outcomes, however, and a 2000 meta-analysis of international literature suggests that, while there may be a small positive effect on breastfeeding, there are too few studies to draw conclusions about the effects of home visiting on children's diets.[13]

b. Preventive Health Services and a Medical Home

Many home visiting programs seek to educate parents about the benefits of preventive health services such as prenatal care, well-baby check-ups, dental care, or immunizations, and to link families with a "medical home" so that children can see the same doctor on an ongoing basis. Such continuity of care is a hallmark of high quality health services. It should lead to decreases in expensive and avoidable visits to emergency rooms, and to more appropriate medical care, including more timely immunizations and well-baby care.

Several HFA program sites report that up to 98% of enrolled families have medical homes, and that large percentages of children (e.g., 97% in three sites in Florida and eight sites in Tennessee) have received immunizations by age 2.[6] However, in most randomized trials, when home visited-children are compared against a control group, the groups make about the same use of preventive health services. The Nurse-Family Partnership, for example, did not find increased utilization of prenatal care.[12] Through the first year of operation, a careful evaluation of Hawaii's Healthy Start, the forerunner of

HFA, demonstrated that more home-visited than control group families had a regular medical provider, but there were no differences in rates of immunization or well-child visits.[9]

Several meta-analyses and literature reviews have also concluded that home visiting programs do not lead to increased use of preventive health services either before or after birth.[13-16]

Home visiting programs are not associated with increases in utilization of preventive health services

c. Child Health Status

Given that home visiting programs only sporadically generate the precursor behaviors associated with improved child health (e.g., increased utilization of preventive services, better diet), it is unlikely that home visiting services will consistently lead to improved children's health status – and that is the case. Whether children's health status is measured in terms of birth outcomes, mothers' reports of their children's health, or children's actual height and weight, few benefits are found.

(1) Birth Outcomes: Preterm Birth and Low Birth Weight

Preventing preterm birth and low birthweight is very difficult, no matter the service strategy employed.[17] Many home visiting programs only enroll children after birth, which means that no effects on birth outcomes is possible. Among programs that enroll pregnant women, the NFP demonstrated fairly large decreases in preterm births and decreased percentages of low birth weight births, but only for very young teens and smokers in the program's first site in Elmira, New York.[12] These findings were not replicated in the program's second study site in Memphis, Tennessee.[12]

The explanation may lie in the initial rates of cigarette smoking in the two sites: while 55% of mothers smoked at enrollment in Elmira, only 9% in Memphis did. To the extent that benefits were derived because the program led to decreases in smoking, these differences in initial smoking rates could have meant that it was not possible to achieve similar effects in Memphis: not enough mothers had the problem behavior that the home visiting program was seeking to alter.[12]

(2) Child Health Status and Physical Growth

Other studies have assessed the effects of home visiting on children's general health status, as reported by their mothers, or on the children's physical growth (height and weight). The Abt Associates meta-analysis of family support programs reports an average effect size of .09 - .12 on these domains, and concludes that family support programs have no meaningful effects on children's physical health and development.[4]

d. Child Safety: Unintentional Injuries and Child Maltreatment

Home visiting programs seek to promote child safety in several ways. A home visitor might help parents to childproof their homes to eliminate household hazards through simple education, by providing vouchers to cover the cost of simple childproofing, or by distributing safety items such as covers for the electrical outlets. Home visitors can also teach parents the importance of safety practices outside the home, such as the use of car

seats. In addition, many programs have a special focus on the prevention of child abuse and neglect. Home visiting is hypothesized to help decrease parental stress and to help parents learn new childrearing and disciplinary techniques, all of which should lead to better parent-child interactions and decreases in abuse and neglect. In other words, if effective, home visiting will help deliver children to school physically safe and psychologically sound.

Generally, meta-analyses suggest that home visiting can help decrease injuries and child maltreatment, depending upon how these concepts are measured.

Home visiting can help decrease injuries and child maltreatment, depending upon how these concepts are measured.

(1) Home Safety Hazards

Although most large studies (e.g., Early Head Start) have not found home visiting effective in helping parents identify and fix home health hazards, a few, scattered studies have. The key may be the complexity of the item that needs to be fixed; the hazards that are the easiest and least expensive to fix are the most likely to improve as a result of home visiting.[13,18]

(2) Unintentional Injuries

Unintentional injuries can be the consequences of safety hazards at home or the disguised results of child maltreatment. Evaluators have treated them as both, and have sometimes used rates of hospitalizations for injuries or ingestions as proxies for measures of child abuse and neglect. For example, in the Nurse-Family Partnership, during the first two years of their lives, children in the home visiting group had fewer hospital visits for any cause or for injuries in Elmira, New York, and fewer health encounters for injuries and ingestions in Memphis. These effects were concentrated among those families with the fewest coping abilities initially.[12] Based on these and other studies, some meta-analyses suggest that home visiting may lower the incidence of such injuries.[13,19]

(3) Child Abuse and Neglect

Although prevention of child abuse and neglect is the primary goal for many home visiting programs, accurately measuring rates of child maltreatment is very difficult. First, abuse is a relatively rare event in the population, and most studies cannot afford to track the number of families necessary to detect its presence. Second, the most direct measure of child maltreatment, reports to Children's Protective Services (CPS), may over- or under-estimate the true rates of abuse and neglect.[20] Evaluators therefore have assessed child maltreatment using a variety of measures, including both initial and substantiated CPS reports, changes in parents' views of parenting or disciplinary practices, and rates of hospitalization or emergency room visits due to injuries and ingestions of poisonous substances, which may be proxies for physical abuse or neglect, as mentioned above.

(a) *Rates of Abuse and Neglect*. Some of the strongest evidence for the potential of home visiting to prevent child abuse and neglect comes from the Elmira, New York, study of the NFP. In that study of home visiting by nurses, a long-term

follow-up of families indicated that participating families had about half as many substantiated reports over the course of the first 15 years of their children's lives than did families in the control group (an average of .29 versus .54 incidents per program participant). This is a large and important difference. The families that benefited most were those in which mothers felt the least sense of control over their lives at enrollment.[21]

Similarly, fewer child abuse and neglect cases were opened in a Southern California PAT program for teens among the group that received both PAT home visiting and comprehensive case management services, although the group that only received PAT home visiting services did not benefit.[22] Randomized trials of Hawaii Healthy Start and Healthy Families America, including a study of an HFA program in San Diego, California, have not yielded positive[6,9,23] results. (See Appendix B for a description of the San Diego study.)

(b) Other Measures of Child Maltreatment. Because assessing actual abuse and neglect rates is difficult, other proxy measures have been used, and these tend to show some benefits from home visitation programs. For example, the NFP program, as mentioned above, showed decreased rates of hospitalizations for injuries or ingestions.[12] Other programs (HFA, Hawaii Healthy Start, and NFP) have generated differences in maternal attitudes related to abuse and neglect, in mothers' self-reported use of harsh discipline, or in mothers' scores on scales associated with risk for abuse and neglect.[14] Mothers in the Hawaii Healthy Start program also reported less maternal injury due to violence in the home (e.g., from a spouse or boyfriend),[9] which is often correlated with child abuse.[24]

(c) Deciphering the Mixed Evidence Concerning Child Abuse and Neglect. On the strength of these and other studies, groups such as the National Academy of Sciences and the Canadian Taskforce on Preventive Health Care have recommended home visiting as a means to prevent child abuse and neglect, especially when nurses are used to visit first-time or teen mothers (as in the NFP).[25,26] One meta-analysis of this field suggests that home visiting programs create relatively large effects (.48 of a standard deviation) on prevention of child abuse and neglect,[11] but most other recent meta-analyses have judged the evidence too conflicting to reach solid conclusions,[13,19] or the benefits too small to be meaningful.[4]

It is clear that some home visiting programs have prevented child abuse and neglect, but what accounts for the wide variation in results and the many programs that do not yield benefits? The varied findings may be due both to characteristics of the families and to the services the programs offer.

With respect to families, for example, early results from the Nurse-Family Partnership suggested that the families that benefited most were those in which mothers had low coping skills initially. Subsequent analyses revealed that home visiting services did not prevent child abuse among those families that experienced a great number of domestic violence episodes (about 21% of the families in the Elmira nurse-visited group),[21] and that nurse-visited and control group families experienced similar rates of

abuse and neglect until there were three or more children in the family. It was only when families had three or more children that the rates of child abuse among home-visited and control group families diverged.[27] These NFP results suggest that benefits will be greater for families with fewer coping skills initially and with fewer episodes of domestic violence, and that the results may not be seen for a few years, until families grow in size and parents face the challenges posed by rearing more than three children. This may mean that long-term follow-up is needed to detect changes in child abuse and neglect.

In addition, the Abt Associates' meta-analysis suggests that program structure and services may play important roles. Although they concluded that family support programs as a whole had almost no effect on child safety outcomes, the Abt researchers teased out aspects of services that were associated with larger effects: Greater child safety benefits were linked with those family support programs that served families with children under the age of 3 years, that provided case management services, that provided parent-child activities, and that worked with teenage parents (as a large percentage of the Elmira NFP families were). Effect sizes for these types of programs range from .56 to 1.21 of a standard deviation, and programs with all three features (case management, parent-child activities, and a teenage parent population) have the largest average effects (1.40 of a standard deviation), compared with average effect size of .20 for programs with none of these service elements.[4] These are very large and important effects, and suggest that programs seeking to prevent both unintentional injuries and child maltreatment would do well to establish these service elements and focus on teen parents.

The strongest evidence for the benefits of home visiting programs lies in the domains of parenting behaviors, child safety, and the prevention of child abuse and neglect

Targeting services to the neediest or highest risk families (e.g., teens, women with low coping skills), however, can only provide benefits if program services and curricula are up to the task. In a meta-analysis that compared the effectiveness of programs that offered services universally or in a variety of more targeted approaches, the researchers conclude that using screening instruments to recruit families at very high risk for child maltreatment into services may unfortunately bring families into home visiting programs that are ill-equipped to serve them.[28] So, while these families may benefit the most, they can only benefit if they are in the right program, with services tailored to address their needs. (See Appendix E (FAQ7): Should We Target Services to Particular Groups or Offer Them Universally?)

In sum, the strongest evidence for the benefits of home visiting programs lies in the domains of parenting behaviors, child safety, and the prevention of child abuse and neglect, although the evidence concerning child maltreatment derives primarily from measures other than CPS reports. The 15-year follow-up in the NHVP suggests that both short- and long-term benefits may occur, but it and other studies suggest that program effects are dependent upon characteristics of the families they serve, their curricula, and the combination of services that they offer families.

3. Maternal Life Course

Some home visiting programs explicitly seek to help mothers improve their own lives. For example, programs may strive to provide social support so as to decrease maternal stress, relieve maternal depression, and improve mothers' mental health. Other programs seek to help mothers increase employment, complete their education, or defer subsequent births. Both sets of outcomes should benefit the children of these women, too.

Most studies have not yet shown benefits in increasing mothers' social support, their use of community resources, or their mental health.

If women are able to defer the birth of a second child, then they may be better able to leave welfare and find employment. They may be able to move out of poverty, and they may be better able to focus attention on their child, both of which are related to better outcomes for children.[12] Clinical depression can be a barrier to employment, and can also affect mothers' interactions with their children – both of which are likely to contribute to the higher rates of behavior, academic, and health problems seen among children of depressed mothers, so addressing maternal depression should benefit children both directly and indirectly.[29]

Results suggest that, with a few exceptions, most home visiting programs do not lead to large benefits for mothers in these domains.

a. Mothers' Stress, Social Support, and Mental Health

Some of the best evidence for effects in the area of mothers' psychological well-being comes from the UCLA Family Development Project, a small university-based program that employs clinically-trained home visitors to work closely with parents. Home visits are scheduled weekly during late pregnancy and in the first year, then biweekly in the second year, and then fading to phone and follow-up contacts only in the third and fourth years. Home visits are complemented by a weekly mother-infant group and referrals to other services. The program seeks to involve the father and other family members, and, in 87% of families, the father is often or sometimes involved in services. The program relies on the relationship between home visitor and mother to help the mother work through unresolved personal issues, including those related to her current relationships with the father, other family members, and her baby. This very clinically-focused approach has yielded results such as less depression and anxiety on the part of the mother, and more frequent and satisfying support from the partner and other family members. These changes were also associated with better parent-child interaction.[2,30]

For the most part, however, reviewers conclude that most studies have not yet shown benefits in terms of increasing mothers' social support,[6] their use of community resources (an aspect of social support),[7] or their mental health.[4]

b. Mothers' Self-Sufficiency

The best evidence for the potential of home visiting programs to help mothers improve their lives economically comes from the NFP. In the Elmira program site, for

example, over the course of 15 years after the birth of their children, poor unmarried women who had been home-visited had fewer subsequent pregnancies and births, were more likely to delay a second birth, spent fewer months on welfare or receiving food stamps, and had fewer problems due to substance abuse and fewer arrests than their counterparts in the control group. These were large differences: 60 versus 90 months on welfare, for example, and 65 versus 37 months between first and second births.[12] A 1998 RAND Corporation study indicated that these changes in maternal life course among high-risk mothers were primarily responsible for the program's $18,611 in net savings per family to government, and that the program did not produce benefits or cost savings when offered to a lower-risk population.[31]

The sentinel finding for maternal self-sufficiency appears to be a reduction in the rate of subsequent births, which the authors in the NFP believe led to positive changes for parents and children later in life. In Memphis, the second NFP site, subsequent pregnancies were also deferred, although not as much as they had been in Elmira (a 67% reduction in Elmira versus 23% in Memphis at the end of program services), and there were no differences in employment or receipt of AFDC.[12] Follow-up is continuing to determine whether increased benefits will be observed in Memphis over time as they were in Elmira.

In contrast, studies of other large programs have not found many benefits in maternal self-sufficiency. For example, the three-city Teenage Parent Home Visitor Services Demonstration project employed paraprofessionals to help teen mothers leave welfare and enter the workforce.[32] Although home-visited teens spent more time than their control group counterparts in education, they did not achieve any gains in educational degrees; they spent less time in job training; they were less likely to be employed; and they used equivalent amounts of AFDC, Food Stamps, and Medicaid benefits. The program succeeded in promoting greater use of passive contraception, but there were no differences in overall rates of pregnancy or repeat births during the relatively brief follow-up period. (See Appendix B.)

The best evidence for the potential of home visiting programs to help mothers improve their lives economically comes from the NFP.

Similarly, Early Head Start participants did not differ from the control group in their participation in self-sufficiency activities or employment rates in the first 15 months of services. EHS parents who received home visiting services were more likely than control group parents to take part in high school and ESL classes, and in vocational courses, but there were no differences in achievement of educational degrees or credentials, in employment, or in welfare receipt.[7]

One international meta-analysis suggests that home visiting programs have no effect on family size, public assistance, or employment, and too little is known about education to draw any conclusions.[13] The Abt Associates meta-analysis of US family support programs concludes that, with an effect size of .10 of a standard deviation, family support programs generally have "very little effect on parents' economic well-being."[33]

In sum, with the exception of the NFP, few programs have produced benefits in self-sufficiency aspects of mothers' lives.

B. Ready Children

The First 5 California Children and Families Commission has defined "ready children" as follows:[5]

Children's readiness for school:

- Physical well-being and motor development
- Social and emotional development
- Approaches to learning
- Language development
- Cognition and general knowledge

All of the home visiting programs examined in this paper seek to promote children's development. Most have assessed effects on cognitive or language development, but others have examined motor, social, and emotional development, and a few have measured children's behavior.

Results suggest that benefits in children's cognitive development accrue more often among families where there are clearly identified needs to be addressed (e.g., children with physical disabilities and developmental delays). Cognitive benefits are not demonstrated reliably in randomized trials of home visiting programs, although there is a suggestion that home visiting services may help promote early language skills. Social development effects are elusive, although one program found significant long-term benefits in children's behavior.

1. Child Development, Achievement, and Behavior

As described earlier, most home visiting programs seek to promote children's development and achievement by changing how parents interact with their children and by encouraging parents to make their homes more conducive to child development. A few focus more attention on child development goals (e.g., PCHP, HIPPY, and PAT), but they still primarily rely on parents to change their behavior between home visits so as to promote child development. The mixed effects of home visiting in producing changes in parenting and the home environment, health outcomes, and maternal self-sufficiency, suggest that results concerning children's development and behavior will be mixed as well, and they are. Key explanatory factors appear to be the risk status of the children and whether or not services are child-focused.

a. Children's Cognitive Development, Language Development, and Academic Achievement

Many home visiting studies have assessed children's development using standardized tests, and a few have examined children's school achievement. While there

are some positive findings, generally results are very mixed. Center-based, child-focused services or center-based, child-focused services combined with home visiting yield larger and more long-lasting benefits in cognitive development than do home visiting services alone.

Center-based, child-focused services or center-based services combined with home visiting yield larger and more long-lasting benefits in cognitive development than do home visiting services alone.

In this arena, the home visiting studies that have captured a great deal of attention include follow-up studies that compared graduates from three programs in which child development is a primary focus (HIPPY, PAT, and PCHP) with age-mates who did not receive that program's home visiting services. These studies suggest that home-visited children out-perform their peers well into their school years. For example, an assessment of the Arkansas HIPPY program compared children who had participated in HIPPY with two matched groups of third and sixth graders: those who had participated in preschool and those who had no formal school experience prior to entering kindergarten. HIPPY children were less likely to be suspended than children who had no preschool experience. Through the sixth grade, HIPPY children had higher grades and higher achievement test scores in reading and language arts than either group, and higher math grades and scores than the no preschool group. Teachers rated the HIPPY students as better adjusted than either group and their academic performance superior to that of the no preschool group. The groups did not differ on special education placements. The evaluator described the effect size as small in magnitude, but notes the consistent pattern of results.[34] PAT has found benefits for graduates through the fourth grade,[35] and a study of the Parent-Child Home Program suggested that children who had received services were more likely than their peers to have graduated from high school.[36]

More methodologically rigorous randomized trials, however, deliver more nuanced results. They suggest that only some children benefit, and that home visiting may not produce as large cognitive benefits as do center-based services. In another HIPPY evaluation, for example, children's cognitive development, school achievement, and classroom adaptation were assessed for two cohorts of children at each of two program sites and at two points in time. No clear pattern of results emerged: children in the first cohort benefited on some measures at one site but not at the other, or at one point in time but not at the other, and children in the second cohort did not benefit at either site.[37]

Three randomized trials of PAT also showed mixed results. In a Salinas Valley trial, children born to Latina mothers showed benefits on measures of cognitive, linguistic, and social development and self-help behavior.[22] In a Southern California trial, only children whose teen mothers received case management services (either alone or in combination with PAT home visiting services) showed benefits in development, and then only on measures of cognitive development.[22] Finally, in a national trial, only children at one of three inner-city urban sites showed benefits, and then only for social development.[38]

An evaluation of the NFP in Denver suggested that nurse home visiting promoted language development, but only among children whose mothers had low psychological resources (that is, low IQ, low coping skills, and poor mental health) at enrollment into the program.[39] (See Appendix B.)

In sum, home visiting produced child development benefits for some children, in some programs, at some program sites. Results from Early Head Start further suggest that home visiting may offer different benefits than other service strategies. In interim Early Head Start results, when children were two years of age, home visiting services produced a small effect on children's language development (effect size of .13 of a standard deviation), but no effects on cognitive development. Larger effects (.19-.28) were achieved on language development at mixed-approach program sites that offered either home visiting and/or center-based services to families, depending upon the needs of the families. Sites offering only center-based services generated effect sizes of .22 on cognitive development, but did not promote language development.[12] By age 3, however, only the mixed-approach sites produced significant effects in language development (effect size of about .23), and only center-based sites appeared to have any effect on cognitive development.[40] (See Appendix B.)

b. Deciphering the Mixed Evidence Concerning Cognitive Development

Most meta-analyses and literature reviews offer one clear conclusion: large benefits in children's cognitive development are most likely when services focus directly on the child, and not when they rely upon parents to intervene with the child, as most home visiting programs do. Even home visiting programs with more of a didactic child focus (e.g., HIPPY and PCHP) may not result in as much time spent directly with the child as does a center-based early childhood program. The Abt Associates meta-analysis compares the effect of home visiting and center-based early childhood education on cognitive development, and concludes that home visiting services generate an effect size for cognitive development of .26, but programs with early childhood education components generate effects almost twice as large (.48).[4]

Home visiting programs that serve low income populations generate cognitive benefits of about .09 of a standard deviation; but programs that serve only children with special needs produce benefits that are about four times larger.

These Abt analyses include home visiting programs that focus on families with children who have clear physical or developmental disabilities or biological risks (e.g., born low birth weight) as well as those that serve broader groups of children. Although home visiting programs for children with special needs were not addressed in this review, home visiting services appear to promote the development of these children more than for most other children.[4,13,16] The Abt researchers conducted additional analyses and conclude that home visiting services generate cognitive development benefits of moderate size (.36) when services are targeted to children with biological risks, but much smaller (.09) when they are not.[4]

Put another way, the Abt Associates meta-analysis suggests that home visiting programs that serve socially at-risk (e.g., low income) populations generate cognitive benefits of about .09 of a standard deviation; but programs that serve both biologically at-risk and non-at-risk children produce benefits that are about 3 times larger; and programs that serve only children with special needs produce benefits that are about 4 times larger.[4] But, none of these benefits on children's cognitive development were as large as the benefits gained via center-based or very child-focused services offered in conjunction with home visiting.

2. Social and Emotional Development, and Children's Behavior

Because, as described above, home visiting programs can produce small but positive benefits in the mother-child relationship, it is reasonable to expect that strong parent-child attachments may emerge among home-visited families. These attachments create a secure base from which children can explore the world with confidence and curiosity. Children with strong attachments to their parents are better able to take advantage of the opportunities that school offers, to develop better social skills and greater emotional stability, and to steer clear of later child behavior problems and delinquency.

At least one home visiting program has assessed children's long-term behavior, and finds very important benefits. Families who had participated in the Elmira, New York NFP were contacted when the children were 15 years of age, some 13 years after program services ended. Teens who had been born to poor unmarried women who had been home-visited showed significant benefits over the control group in several areas: there were fewer instances of running away, arrests, convictions, cigarettes smoked per day, and days having consumed alcohol in the last six months, less lifetime promiscuity, and parents reported their children had fewer problems related to drug or alcohol use.[12]

The Abt Associates meta-analysis concludes that while family support programs can improve children's social and emotional development (effect size of .22-.26), the programs which have the largest effects on social and emotional development do not rely on home visiting or work with primarily low-income families, but instead target children with developmental risks and/or behavioral problems, have as a goal the development of parent competencies, and tend to use professional staff to work with parents.[4] These are more likely to be programs in which parents have sought help to address a particular existing problem rather than primary prevention programs, and are therefore not the types of programs reflected by the national home visiting models described in this paper.

In sum, benefits in children's cognitive development accrue more often among families where there are clearly identified needs to be addressed (e.g., children with physical disabilities and developmental delays). Benefits are not demonstrated reliably in randomized trials of home visiting programs, although there is a suggestion that home visiting services may help promote early language skills. Social development effects are elusive, although one program found significant long-term benefits in children's behavior.

C. Ready Schools

The First 5 California Children and Families Commission defines "ready schools" as those which, "secure a smooth transition between home and school," among other traits. With a few exceptions (e.g., HIPPY), most of the large, national home visiting programs usually end their services well before children enter kindergarten. But, home visiting programs can help ease the transition of children to school. For example, home visitors can communicate directly or urge parents to communicate directly with their children's public pre-kindergarten program or school regarding the children and their needs. They can make sure that children with special needs are identified early, and they can help parents understand the steps they can take to both ease their children's transition into school, and also to become involved in their children's education.

Most home visiting programs do not measure this aspect of their progress, but it seems sensible that programs administered by school districts would be more likely to be able to accomplish and encourage smooth transitions between home and school. With school-based programs, parents may begin to see the home visiting programs as an extension of the schools, which may personalize the institutions and make parents feel more welcome.

Many PAT, PCHP, and HIPPY programs are administered through school districts, and some have examined the resultant connections parents display with the schools. For example, a survey of parents who had participated in Missouri's statewide PAT program when their children were young reported high levels of involvement in their children's education and schooling in subsequent years. Fully 95% of surveyed parents attended special events at their schools, nearly 67% worked as volunteers in the school or classroom monthly, 75% participated in PTA and PTO meetings, 67% communicated with their children's teachers by phone an average of four times a year, and 65% of parents always assisted with home activities related to school work.[41] A small survey of HIPPY parents in Texas suggests similar effects.[42] Neither study can determine whether the parents were "joiners" who would have become involved in their children's schooling anyway, but the descriptive studies suggest that home visiting linked with schools may result in parents becoming more involved in their children's schools.

Home visiting programs that are linked with schools may result in parents becoming more involved in their children's schools.

V. Delivering Home Visits in Combination with Other Services

The previous section describes mixed results for most home visiting programs, with results most consistently observed in areas related to parenting, including child abuse and neglect, and less consistently observed in child development. These very mixed results are derived from studies of programs in which home visiting was the primary service

strategy. Would benefits be larger if home visiting were combined with other service strategies?

"Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns have the greatest impacts."

For child development and especially cognitive development outcomes, the answer appears to be "yes." Project CARE, a North Carolina research project, compared the development of home-visited children with (1) that of children who received a combination of home visits and center-based group care and (2) a control group. Results indicated that only the children receiving the group-based services and home visiting outperformed the control group.[43]

Some of the child-focused programs that produced the most substantial long-term outcomes for children combined center-based early education services for children with significant parent involvement through home visiting, joint parent-child activities, parent groups, or some other means.[44] In these programs, children demonstrated benefits in academic achievement throughout their school years, and were more productive citizens (less crime and delinquency, for example) as young adults. Similarly, the children in Early Head Start program sites where both home visits and center-based services were offered demonstrated larger and broader cognitive and language development benefits than children in sites which offered only center-based or only home visiting services, although no differences in children's behavior were observed.[7]

The National Academy of Sciences has concluded, "Programs that combine child-focused educational activities with explicit attention to parent-child interaction patterns and relationship building appear to have the greatest impacts. In contrast, services that are based on generic family support, often without a clear delineation of intervention strategies matched directly to measurable objectives, and that are funded by more modest budgets, appear to be less effective."[45] In other words, while parent involvement confers a unique advantage in early childhood programs, it is parent involvement that has been coupled with child-focused programs like a good quality child care or preschool program, that has helped produce the longest-lasting, broadest range, and largest magnitude changes in children.

VI. The Importance of Quality Services

Results of more than 25 years of research on home visiting programs demonstrate great variability across program models, across program goals, across sites, and across families. But, there is one consistent result across all studies: Every home visiting program struggles to deliver high quality services to families. Benefits for children and parents would be stronger and more consistent if program quality were enhanced. Indeed, the National Academy of Sciences concluded that the key to program effectiveness is "likely to be found in the quality of program implementation…"[46]

Benefits for children and parents would be stronger and more consistent if program quality were enhanced.

The following are the primary components of program quality:

- family engagement,
- the content and delivery of the curriculum,
- staffing, including the skills and abilities of home visitors to forge relationships with the families,
- cultural consonance between the program and its clientele, and
- developing appropriate responses to those high-risk families that are facing depression, substance abuse, or domestic violence.

Research suggests that typical home visiting programs struggle with all these aspects of quality, but that dedicated quality improvement efforts can lead to better services for families, and that those high-quality programs are more likely to produce benefits for children and families.

A. Family Engagement

All home visiting programs struggle to enroll, involve, and retain families in home visiting services and in the additional services they offer, such as parent group meetings. Of course, many other types of parent education and early childhood programs also report difficulties in engaging parents.[47] But, for an intervention such as home visiting, in which the total scheduled amount of contact between a family and home visitor might be as few as 12 hours per year, decreasing that contact can have a substantial effect. Programs can and should take action to address four aspects of engagement: enrollment, intensity of services, attrition, and activities undertaken by families between home visits.

1. Enrollment

Up to 40% of families that are invited to enroll in these programs choose not to participate,[9,12,39] with refusal rates highest for programs associated with research studies. In contrast, other non-research programs report much lower refusal rates: 2%[48] - 6%[49] in programs that offer a single home visit to all families with newborns, or all first-time or teen mothers in a community; and 8-12% in programs that seek to screen and then enroll high-risk mothers into services.[48,50] And, some programs which offer services to all families in a community have no problem with refusals and instead have waiting lists filled with families clamoring for services.[51]

2. Intensity of Services

Once enrolled, families in most programs receive about half the scheduled number of home visits, no matter the intended frequency of visits.[52] For example, through the first year of Hawaii Healthy Start, the forerunner of HFA, in which families were intended to receive visits every week, families that were still enrolled at the end of the year had received just 22 visits (42%).[9] In three evaluations of PAT programs, families averaged 38%, 56%, and 78% of the expected number of monthly visits.[22,51] In the Nurse-Family Partnership, where visits vary in frequency beginning with weekly visits and then reducing to quarterly, families received averages of 32 (53%) and 33 (55%) visits at two

program sites, rather than the initially scheduled 60 visits.[12] In Early Head Start, none of the 10 programs that planned weekly visits were able to achieve them consistently; sites were typically able to complete at most about two visits per month.[53] The Teenage Parent Home Visitor Services Demonstration Evaluation Project averaged only 38% of its scheduled visits by paraprofessionals to teenage mothers on welfare, even though missed visits were supposed to result in financial sanctions.[32] An exception to this general pattern may be the PCHP where program administrators report a 90% completion rate for its twice-weekly home visits.[54] If this is accurate, it may be because the PCHP brings toys and books into the homes of participants, and participants may be more likely to welcome visits in order to receive those tangible gifts.

Families receive about half the scheduled number of home visits…. Typical attrition rates hover at about 50 percent.

Generally, however, missed visits are common, and they may reflect factors as mundane as bad weather that makes it impossible for home visitors to travel, or family issues (e.g., disinterest, the chaotic nature of some families' lives, or their inability to juggle time commitments between home visiting, work, and family). In Early Head Start, home visitors tried to schedule evening visits to reach working families, but many parents were too tired at the end of a long day to have a home visit.[55] No matter the cause, once an appointment is missed, home visitors with tight caseloads may find they are unable to reschedule visits until the next regular appointment time rolls around again, with the consequence that families receive less intensive services than planned.

Although no studies have been conducted to demonstrate the minimum number of home visits necessary to create change, it seems intuitively reasonable that some threshold number of visits must be completed before change can occur, and that too few visits will hamper the formation of the relationship between home visitor and parent and result in spotty coverage of the program's curriculum. Studies of PAT and NFP suggest that families that receive more contacts benefit more.[56] A precise minimum threshold is unknown, but researchers have speculated variously that four visits,[16] three to six months of services,[1] or more than 6 months and 12 home visits[57] may be required before change can occur. For programs in which the intended service intensity is fairly low (e.g., monthly), this may be a particular problem because it may mean that the threshold minimum number of visits is never crossed. Indeed, some PAT evaluators have concluded that, "The typical "dosage" of home visits is probably insufficient to result in sizable benefits to children."[58]

3. Attrition

Studies of home visiting programs suggest that between 20% and 80% of enrolled families disengage from the programs before services are scheduled to end, with typical attrition rates hovering at about 50%. (See Table 2 for examples of attrition from some recent studies.) The reasons for leaving usually include moving out of the community and returning to work, as well as disinterest, so some of this attrition is clearly outside the control of the home visiting programs.

In other cases, however, the design of the home visiting program or the decisions of the program staff affect attrition. For example, a study of HIPPY suggested that the program's design of operating only during the academic year may have increased attrition because some families lost interest during the summer months.[37] A study of Hawaii's Healthy Start program revealed that programs operated by three administering agencies had dramatically different attrition rates ranging from 38% to 64% over one year, which reflected differences in their policies toward holding onto hard-to-reach families. The Hawaiian agencies responded by analyzing their enrollment and retention rates and developing new performance guidelines regarding time from assessment to first home visit, home visit frequency, and program attrition.[59]

Home visiting programs that have high attrition rates should make sure that they are offering services that their customers want.

The consistency of the attrition findings, observed in home visiting studies for years,[60,61] suggests that the findings cannot be dismissed out-of-hand as the products of poorly implemented programs. The client engagement and attrition rates in home visiting programs are analogous to consumer decisions to purchase services in other businesses. Home visiting programs that have high attrition rates, like any business, should make sure that they are offering services that their customers want. As the National Academy of Sciences concludes, "…the failure of families to continue to participate in an early childhood program may indicate the need to reevaluate the goals of the intervention, the nature of the services that are provided, and the goodness-of-fit between what the program offers and what the target families perceive as their needs."[62] Changing employment patterns, driven by welfare reform, is a special problem, and the NAS further recommends that a "significant restructuring of program practices" may be in order to suit parents' work schedules as more low-income families are required to enter the workforce.[63] Some home visiting programs such as HIPPY have adapted and now offer "home visits" with parents at their workplace, or at child care centers when parents pick up their children at the end of the day. (See Appendix C-3 for a description of HIPPY.)

4. Activities Undertaken by Families

Evaluators of PAT suggest that three other kinds of engagement are important to the success of home visiting: parents must "be involved" and interested during the home visit itself, they must "do the homework" between home visits, and then, ideally, they should also "look for more" activities between visits, such as attending parent group meetings.[51]

In their study of three inner city PAT programs, the researchers found that the parents whom home visitors rated as less involved during their home visits tended to drop out of the program, that many families did not do the homework between visits, and that only about 1/3 of the families attended a parenting group over the course of a year.[51]

Other reports reinforce this finding. In one study, many HIPPY parents did not work with their children the intended 15-20 minutes each day, perhaps accounting for the varying outcomes across families and sites.[37] Although 11 of 13 Early Head Start

Table 2.
Attrition Rates: Percentage of Families No Longer Enrolled by Month, As Reported in Recent Evaluations of Home Visiting Programs

# Months	Oregon HFA[50]	San Diego HFA[23]	HA Healthy Start[59]	Sacramento ABC/Cal-SAHF[69]	NFP: Denver nurses[5]	NFP: Denver paraprofessionals[6]	NFP: Site A[7]	NFP: Site B[7]	NFP: Site C[7]	NFP: Site X[7]	NFP:n Site Y[7]	Salinas PAT[8]	Teen PAT[8]	Urban PAT[8]
1				5										
2				12										
3			10	21										
4														
5														
6	40		30	35										
7														
8														
9			44	42										
10														
11														
12			51	44										
13														
14														
15														
16														
17														
18				46										
19														
20														
21														
22														
23														
24			70		38	48	23	37	43	59	73		57	56
25														
26														
27														
28														
29														
30														
31														
32														
33														
34														
35														
36		40	79									43		

program sites providing home-based services also offered regular group socialization activities, only two programs achieved regular participation by at least half of the families.[55]

In sum, when behavior change in children is predicated upon behavior change in parents but parents' behavior does not shift, then benefits for children will be much harder to achieve.

B. Staffing

Home visiting programs rely upon staff to forge relationships with families and to convey the program's content to them. Hiring, training, and retaining the right people is imperative, and many programs struggle with high levels of turnover, which can undermine the connections parents feel with programs. (See Appendix E (FAQ5): Whom Should We Hire as Home Visitors?)

1. The Home Visitor

The home visitor's role is critical. From the point of view of families, home visitors *are* the program. They draw families to the program, and they deliver the curriculum. Home visitors must have the personal skills to establish rapport with families, the organizational skills to deliver the home visiting curriculum while still responding to family crises that may arise, the problem-solving skills to be able to address issues that families present in the moment when they are presented, and the cognitive skills to do the paperwork that is required. These are not minimal skills, and there is no substitute for them if programs are to be successful.

Hiring, training, and retaining the right people is imperative.

The debate about home visitors has usually been framed as a debate about professional versus paraprofessional workers, or about visitors from one profession such as nursing versus another.[12,64] Such debate has important implications for program operations because labor accounts for most of program costs, and home visitor backgrounds and training drive labor costs.[65] With just a few exceptions, however, research provides no direct comparison of the effectiveness of professional versus paraprofessional visitors, or one type of professional versus another.

One exception is a recent study of the NFP in Denver, Colorado, which directly compared the effectiveness of nurse and paraprofessional home visitors.[39] Results indicated that paraprofessionals produced benefits about half the magnitude of those produced by nurses – a magnitude that was not large enough to differ significantly from the control group for any outcome, while nurse-visited families did benefit more than control group families in some areas (e.g., deferral of second pregnancies, maternal employment in the second year of the child's life, and mother-infant interaction).[66] (See Appendix B for more details on this study.)

Some argue that nurses provide special benefits: their association with the health care system helps remove stigma that families might otherwise feel if they believe that they are in a program to improve their parenting or to prevent child abuse; pregnant women and new mothers may be more receptive to the health-related information that nurses can provide because the mothers are experiencing so many physical and health changes; and the training that nurses receive may equip them to make sure that they reinforce program protocols, even if other events intervene to pull them away.

Extremely well-trained visitors are needed to serve families who are facing multiple, complex issues

Most researchers believe it is not possible at this time to conclude that individuals from a particular professional or educational discipline are better home visitors than others,[64,67] but many of the most recent studies of programs that employed paraprofessionals produced either no or only very modest results.[23,32,39] Case reviews in a study of an HFA-type home visiting program in San Diego suggested that paraprofessional home visitors did not recognize and/or did not follow-up appropriately with families with mental health, substance abuse, and domestic violence problems.[23] It seems likely that extremely well-trained visitors are needed to serve families who are facing multiple, complex issues.[67]

This means that the workers will need something beyond a high school diploma if they are to work with high-risk families, and, ideally, will have some experience or training in early childhood or the helping professions. One study of paraprofessional and nurse home visitors suggested that paraprofessionals could produce outcomes approximately equivalent to the outcomes produced by nurses, so long as the paraprofessionals participated in an intensive, 6-month training program before beginning to serve families.[68] Most home visiting programs do not offer training of this length.

2. Turnover

Because the connection between home visitor and family is the route through which change is hypothesized to occur, turnover among home visitors can be a serious problem. In the NFP in Memphis, for example, turnover among nurses was 50%, and the evaluators suggest that this may be at least part of the reason that results were more limited in Memphis than in Elmira.[12]

Turnover may be a special problem in programs using paraprofessionals. The San Diego HFA program reported 70% turnover over 3 years among its paraprofessional home visitors,[23] and Sacramento's Birth and Beyond Cal-SAHF program reported 73% turnover over 18 months.[69] (See Appendices B and C, respectively, for descriptions of these programs.) For many paraprofessionals, home visiting may be their first job, and they may not have the work-skills to keep it. Other paraprofessionals may successfully use the experience they gain as a home visitor to advance their careers and move to another job, especially in regions with booming local economies. A survey of home visiting programs in San Mateo County confirms that turnover is especially an issue

among paraprofessional home visitors,[70] and there is some evidence from the Early Head Start program evaluation that low wages, averaging $9.77 per hour in that program, contribute to staff unhappiness.[53]

If turnover is higher among paraprofessionals than professionals, then hiring paraprofessionals for the up-front salary savings they appear to provide may be short-sighted. By the time hiring and training costs for replacements are factored in, paraprofessionals may be about equivalent in cost as professionals. And, if staff turnover weakens rapport with families, then the extra turnover may result in weaker program outcomes, too.

A survey of home visiting programs in San Mateo County confirms that turnover is especially an issue among paraprofessional home visitors

3. Supervision

No matter their skill level or professional status, home visitors need close supervision. A good supervisor can help home visitors deal with the emotional stresses of the job, maintain objectivity, prevent drift from program protocols, provide an opportunity for reflection and professional growth, and model the relationship that the home visitor should establish with the parent.[64] Home visiting can be a lonely job, and visitors in small programs may work largely on their own, sometimes without anyone to turn to when problems arise. The best programs build in enough time for the supervisor to meet regularly with the home visitors and to accompany them on occasional visits to families.

C. Curriculum

Home visitors rely on the program's curriculum to help them change families. The curriculum must be geared to the program's goals, and the content must be delivered as intended, or the program's effectiveness will be limited. (See Appendix E (FAQ1): Which Home Visiting Model Should Be Selected?)

1. Curriculum Content

It may seem an obvious point, but the curriculum for a home visiting program should be crafted so that it addresses the program's goals. The curriculum should address explicitly how families can alter the risk factors, barriers, or behaviors that must be changed if the program's goals are to be achieved. For example, national estimates suggest that low birth weight rates could be cut by 20% if smoking during pregnancy were eliminated.[17] Programs that seek to improve birth outcomes should therefore make sure that their curricula include the latest information about how to help pregnant women stop smoking. Programs that seek to help women leave welfare and enter the workforce should include a focus on helping mothers defer subsequent pregnancies. Programs that seek to prevent child abuse and neglect should address the presence of domestic violence in the home.

It may be difficult to identify the linchpin behaviors that must be changed before each goal can be achieved, and some goals may need to be addressed via multiple routes. But, if programs can focus on removing the barriers, then success will be much more likely.

2. Curriculum Delivery

The curriculum must be geared to the program's goals, and the content must be delivered as intended.

Once the curriculum is in place, home visitors must deliver it. Unfortunately, research suggests that may not always occur. Videotapes of several home visits in the Salinas Valley PAT program indicate that some home visitors were staying only 20-45 minutes, rather than the intended 50-60 minutes, suggesting that the content of the visits probably differed across visitors.[22] A study of the NFP in Denver employed both nurses and paraprofessional home visitors and discovered that, in general, nurses spent more time on physical health during pregnancy and on parenting after delivery than did paraprofessionals, while paraprofessionals spent more time on pregnancy planning, education, work, and family material needs, even though both were trained to deliver the same curriculum.[71] Early Head Start evaluators reported that, "…some programs reported facing challenges in trying to complete planned child development activities during home visits, because parents placed greater emphasis on family development needs."[72](See Appendix B for more details about these studies.)

Of course, some deviations from the model are expected and may even be encouraged as home visitors individualize services to meet families' needs. Home visitors *should* set aside the day's curriculum to help a mother deal with the immediate crisis caused by an abusive spouse, an impending eviction, or the loss of a job.

Nevertheless, if programs are consistently unable to deliver the content, program effectiveness will be limited. Home visiting programs only achieve those goals on which they focus. When the Teenage Parent Demonstration Program provided extra training and encouragement for its home visitors to address contraception, rates of contraceptive use began to rise.[32] When San Diego's Healthy Families America program increased training and focus on the use of health care services, the use of those services increased.[23]

Home visitors spend only limited time with their families, and the more focused they and their messages can be, the more likely that progress will be made. Programs should therefore monitor this aspect of program implementation.

D. Cultural Consonance

Parenting practices are strongly bound by culture. Parents of different cultures possess strongly held beliefs about the best approaches to handling sleeping, crying, breastfeeding,[47] discipline,[67] early literacy skills,[73] and obedience and autonomy in children.[67] Further, it appears that the same parenting practices can yield different results for children from different cultures. For example, one recent review suggests that

although an authori*tative* parenting style may be associated with positive outcomes for white children, a more authori*tarian* style may be associated with more positive outcomes for African Americans and Asian Americans.[67]

This suggests that the advice that home visitors give to families will not always be consonant with the family's beliefs about parenting. Some parents of color who participated in PAT, for example, characterized some home visitor advice related to the avoidance of physical punishment (African-American and Latino families) and the promotion of children's autonomy (Latino families) as "white people stuff" and ignored it. White working class families also sometimes questioned home visitors' advice regarding parenting practices, including reading daily to infants.[51]

These different beliefs may be especially important in families in which mothers live with their mothers or extended family, because even if the mother in those families is persuaded that she ought to change an aspect of her behavior, she must also persuade the rest of the family. Such change can cause strife within the family,[47] and, therefore, some interventions seek to involve grandparents, fathers, or other family members.[30,74] Early Head Start programs, for example, employ a variety of strategies to engage fathers.

Although culturally-bound parenting beliefs may influence program outcomes, the differences are not consistent across program models or across program goals. For example, in the PAT Salinas Valley project, children of Latina mothers benefited more than other groups on child development outcomes.[22] In Early Head Start, however, African-American children benefited most, with very few benefits for Hispanics when children were 2 years of age, [75] although both groups benefited more than white families by the time children were 3 years of age.[76] In San Diego's HFA program, white but not African-American or Hispanic women deferred second pregnancies.[23]

The National Academy of Sciences concludes that "…parenting interventions that respond to cultural differences in a dismissive or pejorative manner are likely to precipitate significant conflict or be rejected as unacceptable."[77] This may contribute to high attrition rates.

"…parenting interventions that respond to cultural differences in a dismissive or pejorative manner are likely to precipitate…conflict or be rejected…"

The issue of cultural consonance is especially important in multicultural California. All the large home visiting program models have been employed to serve families from many cultures. The California programs profiled in Appendix C, for example, serve white, African-American, Hispanic, Asian American, and Native American families, and immigrants from many nations. Nevertheless, research has yet to catch up with the diversity that is part of the fabric of life in the state, and, while there have been several studies of home visiting with white, African-American, and, to a lesser extent Hispanic, families, there have been far fewer with Asian-Americans or other groups.

Despite the sparse research, programs should institute some minimum standards: While ethnic and racial matching of home visitors to families may not be necessary,[64] home visitors should speak the language of the families they are visiting and should understand their culture, and, especially, their beliefs about parenting, health practices, and the roles of women. To the extent possible, home visitors should involve members of the extended families of the mothers they visit.

Because families may withdraw when they hear advice with which they disagree, home visitors may be tempted to refrain from broaching those touchy topics where they know that the program may recommend an approach other than the one embraced by the culture of the families they are visiting. While steering clear of controversy may keep families in the program longer, tenure in a program by itself will not lead to benefits for parents or their children. The key is to keep a focus on the specific goals of the program, and to make sure that home visitors find ways to return to that advice, relying upon their relationship with the families to help persuade parents to change their behavior.

E. Serving High-Risk Families

As home visiting programs extend their outreach to families at higher levels of risk, they face increasing challenges in developing curricula that can address the needs of those families. For example, HFA uses a screening tool to select higher-need families; the NFP only enrolls low-income, first-time pregnant women; and programs drawing their clientele from TANF rolls may find that more and more women have higher levels of need as most others have already entered the workforce. For most programs, therefore, quality services require having curricula and staff in place to serve a high-risk population.

Up to 50% of families in some home visiting programs have symptoms of clinical depression.

Three issues deserve particular mention: (1) domestic violence in families; (2) maternal mental health problems, especially depression; and (3) substance abuse. Results from many home visiting programs suggest that these issues are among the hardest for home visitors to recognize or to address effectively, and, along with contraception, are the issues that they feel least comfortable discussing.[23,69,78] But, these are precisely the issues that are most likely to stymie progress for parents and to harm their children.

For example, about 20% of the general population, as many as 30-40% of the welfare population,[29] and up to 50% of families in some home visiting programs have symptoms of clinical depression.[23,69,78] All the women enrolled in the HFA program in Lancaster, California had mental health issues upon initial screening.(See Appendix C-2.) Fully 16% of the caseload in an HFA program in Oregon experienced domestic violence just within the first 6 months after enrollment,[50] and 48% of the families experienced domestic violence in the Elmira, New York site of the NFP over a period of 15 years.[21] In the Oregon HFA program, families that experienced domestic violence within the first 6 months of their children's lives were three times more likely to have physical child abuse

confirmed than families without domestic violence during that six-month window.[50] Home visiting services must be modified to respond to domestic violence and these other issues. These are sentinel events that have substantial impact on children over the long run.

F. The Malleability of Quality

There is heartening evidence that program quality can be monitored, shaped, and improved. For example, the experience of Hawaii's Healthy Start program indicates that program sites can and do have some degree of control over attrition rates. A quick feedback loop in which data on program performance is fed back to program managers is one mechanism by which these variations can begin to be understood and controlled. The Sacramento County Birth and Beyond program has also used data in this way. (See Appendix C-7 for a description of this program.)

When quality improves, outcomes for children improve, too. Early Head Start sites that had early, full implementation of the program's performance standards generated greater benefits in children's development than did sites which had not yet met the standards.[79] In Hawaii's Healthy Start program, program sites that delivered services with the greatest fidelity to the model had the greatest effect on mothers' mental health.[78]

VII. CONCLUSIONS

Home visiting services can produce the results that prepare children for school, but they do not always do so in practice. And, benefits are often small. When averaged across program models, sites, and families, results for most outcomes are about .1 or .2 of a standard deviation in size, an effect size that is considered small in human services. Effects are most consistent for outcomes related to parenting, including the prevention of child abuse and neglect (depending upon how child maltreatment is measured). Home visiting programs do not generate consistent benefits in child development or in improving the course of mothers' lives. Families in which children have obvious risk factors (e.g., they are biologically at-risk, developmentally delayed, or they already have behavior problems) appear to benefit most. Some studies also suggest that the highest-risk mothers (e.g., low income teen mothers; mothers with poor coping skills, low IQs, and mental health problems) may benefit most.

For every outcome, as many as half of the studies and programs demonstrate extremely small or no benefits at all. But, for every outcome, a few programs or program sites demonstrate larger benefits, and it is those more positive results which have driven the expansion of home visiting programs and which illustrate the *potential* of home visiting.

The mixed and modest results, however, illustrate just how fragile an intervention home visiting can be. The most intensive national models are slated to bring about 100 hours of intervention into the lives of families. More typically, programs deliver perhaps

20 or 40 hours of intervention over the course of a few years. That is not much time in which to address issues as complex as child abuse and neglect, school readiness, and deferral of second pregnancies. But, that is the task that has been set for home visiting programs. It is therefore important for policymakers and practitioners to keep their expectations modest about what can be accomplished through any single intervention.

Nevertheless, high quality home visiting programs can play a part in helping prepare children for school and for life. Together with other services such as center-based early childhood education, joint parent-child activities, and parent groups, home visiting can produce meaningful benefits for children and families. For that reason, home visiting services should be embedded in a system that employs multiple service strategies, focused both on parents and children.

Even in such a system, the key to effectiveness is quality of services. Only the best home visiting programs have a chance to benefit children and parents, and funders and program administrators must strive to make each funded home visiting program a strong, high quality program.

To be effective, programs must focus on the goals that they seek to accomplish and make sure that their curricula match those goals, that their staffs are in sync with the goals, and that the families they serve receive information and assistance related to those goals. Programs must seek to enroll, engage, and retain families with services delivered at an intensity level that is as close to the standards for their program model as possible. They should hire the best, most qualified staff they can, and pay them wages that will encourage them to stay. They should seek the counsel of their clients to make sure that they are offering services that their customers want and need. The good news is that quality is malleable, and that programs that set performance standards, monitor their progress toward achieving them, and make corrections along the way are much more likely to produce benefits.

Finally, funders and administrators should consider home visiting services from the point of view of parents and children. To that end, home visiting services should be coordinated within each community so that families receive referrals to the home visiting program that best meets their needs, home visiting programs share training and resources, and families are not faced with multiple visitors.

Home visiting services have the potential to build school readiness for children. They are best delivered as one of a range of community services offered to families with young children. They are not a silver bullet for all that ails families and children, but then no single program or services strategy can be. When done well, home visiting services recognize and honor the special role that parents play in shaping the lives of their children, and they can help create ready families and communities, ready children, and ready schools.

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76. Love, J.M., Kisker, E.E., Ross, C.M., Schochet, P.Z., et al. (June 2002). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start. Volume I. Final Technical Report*. Department of Health and Human Services, Washington, DC. Available at http://www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html
77. National Research Council and Institute of Medicine (2000) *From neurons to neighborhoods: The science of early childhood development*. Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press, p. 371.
78. Windham, A., Duggan, A.K., Rohde, C., Young, E., et al. 2000? Comprehensive evaluation of the Hawaii Healthy Start program: Effects on maternal mental health, substance use and social support at one year. 11th Annual Research Conference Proceedings.
79. Love, J.M., Kisker, E.E., Ross, C.M., Schochet, P.Z. et al. (June 2001) *Building their futures: How Early Head Start programs are enhancing the lives of infants and toddlers in low-income families. Volume II: Technical Report, Appendixes*. Prepared for Commissioner's Office of Research and Evaluation; Administration on Children, Youth and Families; U.S. Department of Health and Human Services, Washington, D.C. Available at http://www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html

APPENDIX B.
META-ANALYSES, LITERATURE REVIEWS, AND RECENT STUDIES OF HOME VISITING PROGRAMS

CONTENTS

I. INTRODUCTION AND DEFINITIONS

Home visiting research has blossomed in the past two decades, and new studies continue to be produced each year. This Appendix is an annotated bibliography of several of the most recent literature reviews and meta-analyses, and of some significant research studies that were published after those reviews were compiled. The studies, literature reviews, and meta-analyses listed in this Appendix are the primary sources of information that were used to form the conclusions reached in the main report.

Traditionally, researchers have undertaken *literature reviews* when they wanted to summarize the results of a field. The author of a literature review searches the published and unpublished literature for reports, reads the reports, and then uses his or her own judgment to divine the patterns that emerge. Standard rules of thumb, based on statistical probability, are used to determine if results in any one study are really due to the intervention, or are merely flukes of chance. If the author of the literature search is not careful, it is possible to miss patterns of benefits, if the benefits are too small in magnitude to reach statistical significance in individual studies.

A newer approach is the *meta-analysis*. The author of a meta-analysis also searches the literature for and reads studies, but then the author uses statistical techniques to combine the results of similar studies to generate an estimate of the magnitude of the benefits produced by programs of similar types. The benefit of such an approach is that if each of several studies produced only small benefits that did not rise to the level of statistical significance, a meta-analysis could combine those results and detect the presence of a pattern of small benefits. The challenge is that the meta-analysis should only combine studies that are similar enough that combining them makes sense. If home visiting programs have very different goals or operate in very different contexts (e.g., in other countries), for example, it might not make sense to combine them in a meta-analysis.

II. META-ANALYSES

Table 1 summarizes the key findings from several of the most recent meta-analyses of home visiting programs. Greater detail about each of the meta-analyses included in Table 1 appears below.

A. Meta-Analyses Derived from the Abt Associates Database

As part of a contract with the federal government to assess family support programs, Abt Associates undertook a meta-analysis of the family support literature since 1965. The Abt Associates database included all family support programs. Appelbaum and Sweet used the Abt database to conduct a meta-analysis that included only those family programs that employed home visiting. In contrast, the Abt researchers conducted some analyses that focused on family support broadly, some on home visiting programs, and some that contrasted the use of home visiting with other service strategies. The following summarizes the results of both efforts.

Table 1.
Summary of Meta-Analyses of Home Visiting Programs

	Abt Associates (Short-Term)	Abt Associates (Follow-Up)	Appelbaum & Sweet	Elkan et al	Roberts et al	Guterman	MacLeod & Nelson	Hodnett
READY FAMILIES AND COMMUNITIES								
Parenting Knowledge/Attitudes/ Behavior (HOME)	.18/.25/.30	-/.18/ -	.10	+		+		
Child Health and Safety								
Nutrition: Breastfeeding/Diet				+/?				
Preventive Health Services & Medical Home				-				
Child Health Status								
Birth Outcomes: Preterm Birth and LBW								-
Child Health Status and Physical Growth	.09	-		-				
Child Safety	.15	-						
Home Safety Hazards								
Unintentional Injuries				+				
Child Abuse and Neglect			.17-.48	?	?		.41	
Maternal Life Course								
Stress, Social Support, Mental Health	.09	.17	-	+/?				
Economic Self-Sufficiency	.10	.39	-	?				
Education			.11	?				
READY CHILDREN								
Children's Cognitive and Language Development, Academic Achievement	.09/.26/.36*	.30		+				
Social and Emotional Development, Child Behavior	.15	.09		+				
READY SCHOOLS								
Parental Involvement with Children's Education/School Events								

Notes: + indicates positive effect shown; - indicates no effect; ? indicates not enough adequate studies to draw a conclusion.
Numerical values are in standard deviation units. Variation across meta-analyses is driven by the studies included. Abt Associates: U.S. only; all family support (not just home visiting) programs, unless otherwise noted. Hodnett: broad-based social support. Elkan et al, Roberts et al, MacLeod & Nelson, and Hodnett: home visiting only, but include international studies. Elkan et al and Abt Associates (except where otherwise noted) include children with special needs.
* Only home visiting programs: .09=untargeted population; .26=both special needs and other children; .36=targeted to children with special needs only. See also Appendix A.

1. **Appelbaum, M. & Sweet, M.A. (1999) Is home visiting an effective strategy? Results of a meta-analysis of home visiting programs for families with young children. University of California, San Diego. Presented at a workshop of the Board on Children, Youth, and Families of the National Academy of Sciences, Washington, D.C. Available from Mark Appelbaum: mappelbaum@ucsd.edu**

   Employs the database of studies from Abt Associates but examines only programs employing home visiting services as the primary means of service delivery. Reports the following effect sizes:

   - *Child Development*
     - Cognitive child development: .12, p<.01
     - Socioemotional child development. .10, p<.01
   - *Parenting*
     - Parenting behaviors: .10, p<.01
     - Parenting attitudes: .10, p<.01
   - *Prevention of child abuse*
     - Actual abuse: .48, p<.01
     - Potential abuse: .17, p<.01
     - Parent stress: .10, not statistically significant
   - *Maternal life course*
     - Education: .11, p<.01
     - Employment/wages: .00, not statistically significant
     - Reliance on public assistance: -.04, not statistically significant

   The authors conclude:

   a. Effect sizes, while significant, are small for both child and parent outcomes. Their practical significance should be questioned.
   b. There is no evidence that the duration or intensity of the intervention influences effect sizes.
   c. There are no consistent effects across outcome groups for targeted populations.
   d. No consistent effects across outcome groups for primary program goals (e.g., programs that focus on child-related goals do not necessarily achieve child outcomes more than do programs that focus on parent-related goals).

2. **Layzer, J.I., Goodson, B.D., Bernstein, L, & Price, C. *National evaluation of family support programs. Final Report Volume A: The meta-analysis.* Abt Associates, April 2001.**
   Meta-analysis of family support programs, including home visiting programs, conducted since 1965. The authors identified 900 research reports, coded 665 studies (representing 260 programs), and eventually included the most methodologically rigorous of those studies in the meta-analysis. That resulted in two databases: (1) an end-of-treatment database of 351 randomized or quasi-experimental studies of 191 programs, and (2) a follow-up database of 158 randomized or quasi-experimental

studies of 87 programs. Approximately half of these programs included home visiting services as the primary mode of service delivery, and another 12% used home visits to deliver some services. The analyses cover the short-term and long-term effects of the programs and the differential effectiveness of alternative service strategies.

Selected findings:

- Family support services generate small positive effects in children's cognitive development, social and emotional development, and parenting attitudes and knowledge, parenting behavior, and family functioning.
- Services generate statistically significant but very small and perhaps functionally meaningless benefits on children's physical health and development, safety, parents' mental health or risk behaviors, and family economic self-sufficiency.
- Programs that focus on children with special needs have larger effects on children's cognitive outcomes, as do programs that provide early childhood education directly to children.
- In contrast, programs that use home visiting as a primary intervention have weaker effects on children's cognitive outcomes.
- Programs that use professional staff to help parents to be effective adults, and that provide opportunities for parents to meet in support groups are more effective in producing positive outcomes for parents.
- Strategies showing the weakest effects were those relying on home visits, delivered by paraprofessional staff, with non-targeted services.
- Teens benefited from having a case manager, and organized parent-child activities.

The following tables from the Layzer et al paper list the magnitude of the effect sizes for cognitive development in programs with various characteristics. Generally, they show that center-based early childhood education programs and parent peer support groups have larger effects on child cognitive development than do home visiting programs, and that children with biological risks benefit more than other children.

Average Effects on Children's Cognitive Development for Different Program Characteristics: Randomized Studies

Program Characteristic	Present	Absent	Effect Size of Difference
Early childhood education	.48	.25	2.1 s.d.
Targeted to special needs children	.54	.26	2.5 s.d.
Peer support opportunities for parents	.40	.25	.9 s.d.
Home visiting (vs. parent groups)	.26	.49	1.4 s.d.

Average Effects on Cognitive Development of Children with Biological Risks in Programs with and without Early Childhood Education: Randomized Studies

	Targeted to Children At Biological Risk	Not Targeted
Early childhood education	.67	.45
No early childhood education	.50	.26

A difference of .05 represents an effect size of one standard deviation.

Average Effects on Cognitive Development of Children with Biological Risks in Programs with Home Visiting vs. Parent Groups: Randomized Studies

Primary Method of Delivering Parent Education	Targeted to Children at Biological Risk	Not Targeted
Home visiting	.36	.09
Parent peer support groups	.54	.27

A difference of .11 represents an effect size of one standard deviation.

B. Meta-Analyses Derived from The Elkan et al Database

British researchers Elkan, Kendrick, Hewitt, Robinson and their colleagues identified 1218 studies from all over the world, and eventually included 102 studies that met requirements for methodological rigor. The studies evaluated 86 home visiting programs. The relevance of non-United States studies is unclear, given the differences in health and human service systems across countries, the needs of the populations, and the extent to which home visiting is much more common across all socioeconomic strata in European nations. Nevertheless, the review is very comprehensive (at least through about 1996). The authors also published other studies based on the same database to examine the effects of home visiting on immunizations and parenting.

1. Elkan, R., Kendrick, D., Hewitt, M, Robinson, JJA., et al. The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. *Health Technology Assessment* 2000; Vol 4(13).

Conclude that home visiting is associated with improvements in parenting skills and the home environment, child intellectual development (especially among children with low birth weight or failure to thrive), breastfeeding, social support for mothers; and reductions in some child behavioral problems, the frequency of unintentional injury, and maternal postnatal depression. No effects on children's motor

development, immunization rates, preventive health services, emergency room services, or hospital admission rates. Insufficient evidence regarding physical development, child illness, mothers' use of informal community resources or the size of their informal support network; children's diet; mothers' return to education, participation in the workforce, use of public assistance, family size, number of subsequent pregnancies or rates of child abuse and neglect.

2. **Kendrick, D., Elkan, R., Hewitt, M., Dewey, M., et al. Does home visiting improve parenting and the quality of the home environment? A systematic review and meta analysis. *Arch Dis Child* 2000; *82*:443-451 (June).**

   Meta-analysis of home visiting programs from 1966 to October 1996. Included randomized trials and quasi-experimental studies of home visiting programs that included at least one postnatal home visit. Part of a larger meta-analysis (cf. Elkan at al, 2000). Found 1218 references, and eventually included 34 studies that reported HOME scores and/or other measures of parenting. Studies included 12 non-US studies (Canada, UK, Ireland, Bermuda, Jamaica). Concludes that home visiting services were associated with an improvement in the home environment (HOME scores) and improvements in parenting (measured in many different ways).

3. **Kendrick, D., Hewitt, M., Dewey, M., Elkan, R., et al. (2000). The effect of home visiting programmes on uptake of childhood immunization: A systematic review and meta-analysis. *Journal of Public Health Nursing*. 22(1), 90-98.**

   Meta-analysis of studies from 1966 to 1996. Identified 1218 references in the literature, eventually including only 11 studies that met methodological criteria and reported on immunization rates. Includes four non-U.S. studies (Canada, UK, Turkey, and Ireland). "Our findings suggest that multi-faceted home visiting programmes are not sufficient to increase uptake, and that more specific interventions may be required to achieve this." (p. 93)

C. Other Meta-Analyses

Two other notable meta-analyses focus on child safety, including child abuse and neglect. Differences in conclusions illustrate the influence of different studies being included in the reviews.

1. **Guterman, N.B. (1999). Enrollment strategies in early home visitation to prevent physical child abuse and neglect and the "universal versus targeted" debate: A meta-analysis of population-based and screening-based programs. *Child Abuse & Neglect*, 23(9), 863-890.**

   Compared effect sizes from 19 controlled outcome studies across screening-based and population-based enrollment strategies. Effect sizes were calculated on protective services data and on child maltreatment-related measures of parenting. Contrasts programs that are population-based in that they enroll only on the basis of

demographic factors (e.g., everyone in a community, or everyone in a community who is a first-time teen mother – as in the Nurse-Family Partnership), or use active screening-based strategies that assess risk at the individual-level and target services on the basis of psychosocial risk (e.g., using a screen at birth to identify families at high-risk for abuse, or families with substance abuse problems – as in Healthy Families America).

Concludes that each approach produces some benefits, but only the population-based approach produces benefits large enough to be functionally meaningful. Suggests three possible explanations: (1) psychosocial screens may not be accurate at identifying families at risk for future maltreatment; (2) screens may somehow screen in higher proportions of families who are less amenable to change and screen out families who are more amenable to change; and (3) screens may enroll high-need families, but program services may not adequately address their needs.

2. **Roberts, I., Kramer, M.S., Suissa, S. Does home visiting prevent childhood injury? A systematic review of randomised controlled trials. *British Medical Journal*, 1996;312:29-33 (6 January). Available at http://www.bmj.com/cgi/content/full/312/7022/29.**
Meta-analysis of home visiting programs from January 1966 to April 1995. Identified 33 experimental or quasi-experimental trials of home visiting programs and eventually included 11 which reported outcome data on injury or abuse or both. Concludes that home visiting has the potential to reduce the rates of childhood injury, but that results concerning abuse are equivocal, at least in part because the use of reported abuse is problematic in evaluations.

III. LITERATURE REVIEWS

Several literature reviews and volumes of collected studies have been published on home visiting in the past decade, and this paper relies on several of them. Key collections include the following:

A. **Cowan, P.A., Powell, D. & Cowan, C.P. (1998). Parenting interventions: A family systems perspective. In I.E. Sigel and K. Ann Renninger, (eds.), *Handbook of Child Psychology*, Volume 4. *Child Psychology in Practice*, pp. 3-72.**
Literature review of parenting interventions, including home visiting services for young children.

B. **Gomby, D.S., & Larson, C.S. (eds.) (1993). Home Visiting. *The Future of Children*, *3*(3), 1-216.**
Special issue of *The Future of Children* which provides an overview of home visiting programs, their history, underlying conceptual models, and staffing; reviews the research literature through about 1992, including the research on the costs and benefits of home visiting programs; describes international (primarily European) home visiting programs; discusses the context of serving families of color and

families in poverty; and contains a proposal for a universal system of home visiting by the U.S. Advisory Board on Child Abuse and Neglect. Appendices provide contact information for several national home visiting programs. Available at www.futureofchildren.org.

C. **Gomby, D.S. & Culross, P.L. (eds). (1999). Home Visiting: Recent Program Evaluations. *The Future of Children, 9*(1), 1-224.**
Special issue of *The Future of Children* which updates the 1993 issue, and includes reports on the most recent studies of the Nurse Home Visitation Program (now called the Nurse-Family Partnership), Hawaii Healthy Start, Parents as Teachers, The Home Instruction Program for Preschool Youngsters (now the Home Instruction for Parents of Preschool Youngsters program), the Comprehensive Child Development Program, and Healthy Families America. Appendices provide contact and program information. Available at www.futureofchildren.org.

D. **Guterman, N.B. (2001) *Stopping child maltreatment before it starts: Emerging horizons in early home visitation services*. Thousand Oaks, CA: Sage Publications.**
Volume that focuses on the use of home visiting to prevent child maltreatment. Provides background information on child maltreatment, including prevalence and risk factors; the rationale for and the history of home visiting services to prevent child maltreatment; core elements in the delivery of home visiting services; who receives and benefits from home visiting services; addressing substance abuse via home visitation; the role of families' social networks; and empowering parents. Throughout the book, many programs are profiled as examples of practice, and practice principles are outlined.

E. **Johnson, K.A. (May 2001) *No place like home: State home visiting policies and programs*. Johnson Group Consulting, Inc. Report commissioned by The Commonwealth Fund. Available at www.cmwf.org.**
Of 42 states responding to a survey about home visiting, 37 reported having state-based home visiting programs, and three others reported having quality improvement or technical assistance projects that support a range of local home visiting programs. The reasons for launching programs are usually improving parenting skills (81%), enhancing child development (76%), and preventing child abuse and neglect (71%). Concludes that state agencies face challenges and barriers as they try to manage multiple programs, that available funding often drives policy and program decisions, and that programs are often launched with over-promises about results that can be achieved. Case studies and contact information are presented for some state efforts. (Note: California did not respond to the survey.)

F. **McCurdy, K. & Daro, D. (2001). Parent involvement in family support programs: An integrated theory. *Family Relations, 50,* 113-121.**
Summarizes literature on parent engagement in family support programs and proposes a theory of the key factors involved in enrolling and retaining families in programs such as home visiting.

G. Montgomery, D., Phillips, G., & Merickel, A. (September, 29, 2000). *Home visiting programs: Varying costs and elusive effects*. American Institutes for Research. Report submitted to The David and Lucile Packard Foundation for Grant #97-6152.

Reviews literature on costs and effectiveness of home visiting programs. Suggests that the annual costs per family for six major models of home visiting services (in 1998 dollars) are as follows:

$1,341 for HIPPY
$2,118 for PAT
$2,203 for Healthy Families America
$2,995 for Hawaii's Healthy Start
$2,842-$3,249 for the Nurse-Family Partnership (costs are less after three years, when all nurses are trained and full caseloads attained)
$11,935 for the Comprehensive Child Development Program

Describes the components that go into costs for programs (primarily salaries), and the results of time studies of home visitor activities, and includes recommendations for policymakers and program administrators.

H. National Research Council and Institute of Medicine (2000). *From neurons to neighborhoods: The science of early childhood development.* Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff & Deborah A. Phillips, eds. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press.

Comprehensive review of the science of all aspects of early childhood development, including the basic biology of child development, core concepts of child development, the interaction between nature and nurture, the role of culture in development, and the roles of family, economics, child care, community, and intervention programs including home visiting, in promoting child development. Contains recommendations for policy, program, and research.

I. Thompson, L., Kropenske, V., Heinicke, C.M., Gomby, D.S., & Halfon, N. (December 2001) *Home Visiting: A Service Strategy to Deliver Proposition 10 Results,* in N. Halfon, E. Shulman, & M. Hochstein, eds. Building Community Systems for Young Children, UCLA Center for Healthier Children, Families, and Communities. Available at http://healthchild.ucla.edu

Reviews the research literature on home visiting programs; describes program models in California (the Adolescent Family Life Program, Black Infant Health, Cal-LEARN, California Safe and Healthy Families, Early Head Start and Head Start Home-Based Option, Early Start, Family Preservation, Healthy Families America, High-Risk Infant Follow-Up, and the Nurse-Family Partnership); describes funding for home visiting programs in California; offers strategies to strengthen the quality of home visiting programs and to evaluate them; and profiles three programs (The Hope Street Family Center Home Visitation Program; the Fresno site of the Nurse-Family

Partnership; and the Alameda County Children and Families Commission Every Child Counts Initiative)

J. Wasik, B.H. & Bryant, D.M. (2001). *Home visiting: Procedures for helping families*. 2nd edition. Thousand Oaks, CA: Sage.
Provides a broad history of home visiting, including its roots in Europe and America; describes the theories and principles that underlie home visitation, and illustrates those principles with examples of home visiting programs. Significant focus on how to deliver home visiting services well, with chapters on home visitor characteristics, training, and supervision; helping skills and techniques; managing and maintaining home visits; visiting families in stressful situations; ethical and professional issues facing home visitors; and assessment and documentation in home visiting. Includes some examples of forms used by home visitation programs to document family need or service delivery.

IV. RECENT STUDIES OF SIGNIFICANT HOME VISITING PROGRAMS

The literature reviews and meta-analyses described above rarely included studies published after 1999. However, since 1999, several significant randomized trials of home visiting programs, including randomized trials of many of the largest national home visiting models (e.g., PAT, HFA, Nurse-Family Partnership, Early Head Start), as well as a federally-funded evaluation of a paraprofessional home visiting model designed to serve teen parents on welfare, have been completed. In most cases, the newer research includes results concerning both the outcomes of the programs and their implementation, which can provide useful information to program planners.

A. The Teenage Parent Home Visitor Services Demonstration

Evaluation Conducted By: The University of Pennsylvania with Mathematica Policy Research, Inc., and the Health Federation of Philadelphia[e]

Program Goals:

- reduce the long-term welfare dependence among participating teenage parents, in part by helping the teens delay subsequent pregnancies and births
- strengthen the parenting skills and behaviors of the teen mothers

Location: Chicago, Illinois; Dayton, Ohio; and Portland, Oregon

Time: between March 1995 and September 1997.

[e] Kelsey, M., Johnson, A., & Maynard, R. (July 2001). The potential of home visitor services to strengthen welfare-to-work programs for teenage parents on cash assistance. http://www.mathematica-mpr.com/PDFs/potential.pdf

Evaluation: Randomized trial.

Population: 2,400 first-time pregnant or parenting teen parents on welfare, of whom 1100 were randomly assigned to receive home visiting services. Overall, teens averaged 18 years of age, had completed 10.5 years of school, most were pregnant with or parenting their first child, 2/3 were African American, and most lived with a parent or grandparent.

Services: Each demonstration site created two home visiting programs – one operated by the local welfare agency (lots of experience in employment issues but not in home visiting), and the other by a community-based organization (lots of experience in home visiting, but not in employment). Teens either received home visiting services, delivered by one of these two county agencies, or regular Job Opportunities and Basic Skills Training Program (JOBS) services. Teens could be sanctioned (their AFDC payments cut) if they did not complete scheduled home visits.

Staffing: paraprofessionals; 30% had been teen parents; 60% had been welfare recipients. 2/3 African-American. Most had completed high school, and some college, though fewer than 25% had bachelor's degree, and none had professional degrees in the helping professions.

Duration of services: Families received between 6 and 30 months of services, depending upon when they enrolled.

Frequency: Home visits were scheduled weekly, but fewer than half were completed. After 6 months of services, about 1½ visits per month were completed; after 12 months, the rate dropped to about 1 visit per month; after that, it dropped further.

Curriculum: child development, parenting, and employment and support

Baseline and Follow-up Period: Mothers were interviewed at enrollment and also at the end of the service period (which averaged 21 months after intake).

Results – Outcomes:

- *School enrollment*: Trend for home visited teens to spend more time in education than non-visited (24% versus 21%, $p < .10$)
- *Educational attainment*: No difference
- *Job training*: Trend for home visited teens to participate less than non-visited in job training (18% versus 23%, $p < .10$)
- *Employment*: Trend for home visited teens to be employed less (36% of the months versus 41% of the months, $p < .10$)
- *Economic well-being*: Earnings were higher for the home-visited teens, suggesting that, since they were not more likely to be employed, that they might have worked more hours or in higher-wage jobs than non-home-visited teens. However, the differential was greatest in the early months of service, and began to disappear by the end of the follow-up period.

- *Income sources*: no difference between groups in reliance on AFDC or food stamps
- *Medicaid receipt*: no difference
- *Protection from sexually transmitted diseases and unintended pregnancy*: Trend for home visited teens to be more likely to use contraceptives such as NorPlant and Depo-Provera, and condoms ($p < .10$), but only after home visitors received additional training on these topics.
- *Pregnancies and births*: no differences in overall rates of pregnancies or repeat births.

Results – Process:

- High staff turnover, driven by personal circumstances, interest in career advancement, low wages, and burnout and stress
- Staff discomfort in talking about sexual relationships and contraception required special training
- Pre-service and in-service training, and high-quality supervision were critical for working with paraprofessionals

B. Early Head Start

Evaluation Conducted By: Mathematica Policy Research, Inc.[f], and the Center for Children and Families at Teachers College at Columbia University, with the Early Head Start Research Consortium (See Appendix C-1 for a description of Early Head Start.)

History: Established in 1995 with 68 programs, Early Head Start served about 55,000 low-income families with infants and toddlers through more than 660 programs by 2002. The evaluation began in 1995.

Program Goals:

- Improve children's development, including cognitive and language development, social-emotional behavior, and health
- Encourage close, supportive relationships between parents and their infants and toddlers
- Help families become healthier
- Help families become more economically self-sufficient

Population: 3000 pregnant women or families with a child 12 months of age or younger, served at 17 sites across the country.

Evaluation: randomized trial

Period of follow-up: Baseline, and then parent interviews at 6, 15, and 26 months after enrollment; and parent interviews, child assessments, and videotaped parent-child interactions at 14, 24, and 36 months.

[f]Several publications from this evaluation are available on-line at http://www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_intro.html or http://www.mathematica-mpr.com/3rd/Level/ehstoc.htm.

Services: Programs were free to create center-based services; home-based services; or mixed models, in which families could receive either or both center- or home-based services at a single site. Program standards in place for both center- and home-based approaches. Performance standards for home-based services encouraged a focus on child development. Four sites began as center-based programs, seven began as home-based, and six began as mixed-approach.

Staffing: Sites hired both professional and paraprofessional home visitors, though most required that home visitors have a postsecondary educational credential or be working toward one.

Onset and Duration of services: Pregnancy through age 3. Reports summarize results at age 2 and 3.

Frequency: Center-based programs offer a minimum of two home visits each year, in addition to center-based services for children; home-based programs offer weekly home visits and at least two group socializations per month for each family.

Curriculum: most common was *Parents as Teachers* (five programs) and WestEd's *Program for Infant/Toddler Caregivers* (five programs). Other programs used the *Partners in Parenting Education* curriculum, *Early Learning Accomplishment Profile* materials, or *Hawaii Early Learning Profile* materials.

Results – Outcomes:

- *Child Outcomes and Parenting Behavior*: Center-based programs had beneficial effects on cognitive development and reduced some negative aspects of children's social-emotional development. Home-based programs had beneficial effects on language development at age 2, but not age 3, and possibly affected some parenting outcomes, but had no effects on cognitive development. Mixed-approach programs had beneficial effects on language, some aspects of social-emotional development, and parenting outcomes.

- *Parents' self-sufficiency*: EHS had no overall impact on parent income, although parents in mixed-approach and, especially, home-based EHS were more likely than parents in the control group to participate in education and training.
- *Parents' mental health*: Parents in home-based programs displayed less stress, but there were no other effects on parents' mental health.

- *Magnitude of effects*: Where positive effects were seen, the effect sizes were usually not larger than .15-.30 of a standard deviation, with the largest effects coming from the mixed-approach programs.

- *Who benefited most*: Benefits were statistically significant for African-American and white non-Hispanic families, but not Hispanic families at age 2. At age 3, benefits

were statistically significant for African-American and Hispanic families, but not for white non-Hispanic families.

- Benefits for children were greater if families enrolled prenatally.

- Services had the most impact on child well-being among families at moderate risk. Low-risk families showed few benefits, and high-risk families were unfavorably affected.

Results – Process:

- *Implementation matters*: child and parent benefits were more frequent and larger in magnitude for programs that were fully implemented.

- During the first seven months after enrollment, about 57% of EHS families in home-based programs received home visits weekly, and 52% of families reported receiving weekly home visits during the subsequent nine months. Most programs were able to visit families two to three times per month, rather than weekly.

- About 25% of the program group left the program within the first year after enrolling because they (1) moved out of the area; (2) asked to be removed from the program rolls; (3) were removed because of poor attendance or lack of cooperation with program requirements.

- Program staff judged that slightly more than one-third of the research families became highly involved in program services.

- After welfare reform, home-based programs tried to conduct home visits during evenings and on weekends when working mothers were more likely to be at home, but families were often too tired and busy to participate at those times.

- Parent participation rates in parent education and other group activities were low.

C. The Nurse-Family Partnership (Denver)

Evaluation Conducted By: D.L. Olds, J. Robinson, R. O'Brien, D.W. Luckey, et al. (Researchers from the Prevention Research Center for Family and Child Health, the University of Colorado Health Sciences Center, and Cornell University Department of Human Development)[g]

History: The Nurse-Family Partnership began more than 20 years ago as a demonstration program in Elmira, New York, where it was tested with primarily white women. It was tested again in Memphis, Tennessee, in a predominantly African-

[g] Olds, D.L., Robinson, J., O'Brien, R., Luckey, D.W., et al. (2002) Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics, 110*(3), 486-496.

American population. This is a report on the results of a third randomized trial of the program, this time conducted in Denver, Colorado, and comparing the effectiveness of nurse and paraprofessional home visitors. (See Appendix C-4 for additional details about the program and its presence in California.)

Program Goals:

- Improve pregnancy outcomes by helping women to alter their health-related behaviors, including reducing the use of cigarettes, alcohol, and illegal drugs;
- Improve child health and development by helping parents provide more responsible and competent care for their children; and
- Improve families' economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work.

Population: 735 primarily unmarried, pregnant women with no previous live births, who were eligible or Medicaid or had no private insurance. In this randomized trial, 45% of the women were Hispanic, 36% Caucasian non-Hispanic, 16% African American, and 3% American Indian or Asian-American.

Evaluation: randomized trial

Time: Began to recruit participants in 1994

Period of follow-up: At end of the intervention (when children were 2 years of age).

Services: Families randomly assigned to one of three groups: (1) visits by nurses; (2) visits by paraprofessional home visitors; and (3) a control group. All groups received developmental screening for their children at 6, 12, 15, 21, and 24 months of age, and referral services. The first two groups also received home visits from enrollment until the children reached 2 years of age.

Staffing: Nurses were required to have a BSN degree with experience in community college or maternal and child health nursing. Paraprofessionals were required to have a high school education, but no college preparation in the helping professions or a bachelor's degree in any discipline, although preference was given to applicants who had previously worked in human service agencies. Both groups were required to have strong "people skills." Both groups of visitors received 2 months of extensive training. Caseloads were about 25 families per home visitor. Supervision levels were 2 supervisors per 10 paraprofessionals, and 1 supervisor per 10 nurses.

Onset and Duration of services: Prenatal to age 2.

Frequency: Visits were scheduled on a weekly basis initially, fading to less frequent visits after birth.

Curriculum: The curriculum is focused on the goals of the program, and includes visit-by-visit guidelines and detailed objectives. Visitors adapt content of individual visits to match the needs and interests of the families.

Results – Outcomes:
In comparisons against the control group:

- Families visited by paraprofessionals did not differ significantly from the control group on any outcome
- Nurse-visited families showed benefits over the control group on the following outcomes: lower cotinine levels during pregnancy (less smoking); fewer subsequent pregnancies and births; greater employment during the 13th-24th months; better mother-child interaction; less vulnerability on the part of the infants to fear stimuli; language development.
- Neither group showed benefits on the number of cigarettes smoked; use of preventive services; use of emergency housing or food banks; mothers' educational achievement, employment during the 1st-12th months of the baby's life; or AFDC.
- For families in which mothers had low psychological resources (low IQ, low coping skills, poor mental health) at enrollment, nurse-visited families showed benefits in mother-child interaction, the home environment, the baby's response to positive and to anger stimuli, and cognitive and language development.

In comparisons between nurses and paraprofessionals:

- Generally, paraprofessionals generated effects of about half the magnitude as that generated by nurses, but these differences were rarely statistically significant.

Results – Process:

- Nurses completed an average of 6.5 visits during pregnancy and 21 during infancy. Paraprofessionals completed an average of 6.3 visits during pregnancy and 16 visits during infancy.
- Staff turnover: All 10 nurses stayed throughout the duration of the program; 7 of 10 paraprofessionals stayed.
- Nurses spent a greater portion of their home-visit time on physical health during pregnancy and on parenting after delivery than did paraprofessionals. Paraprofessionals spent more time on pregnancy planning, education, work, and family material needs.
- Paraprofessionals had longer average visit times than nurses.

D. The San Diego Healthy Families America Trial (Precursor to Cal-SAHF)

Evaluation Conducted By: J. Landsverk, T. Carrilio, C. Jones, R. Newton, et al. Child and Adolescent Services Research Center (a multidisciplinary consortium of researchers affiliated with Children's Hospital and Health Center-San Diego, San Diego State University, and the University of California at San Diego).[h]

[h] Executive summary available from John Landsverk at jlandsverk@aol.com.

History: Research and demonstration project funded by the State of California Department of Social Services, Office of Child Abuse Prevention, the California Wellness Foundation, and the Stuart Foundation. The project was designed to replicate a Healthy Families America (HFA) program, using the same instruments and tests that were used in the Johns Hopkins trial of the Hawaii Healthy Start program. Hawaii Healthy Start is the forerunner of the HFA program. The San Diego site added some programmatic enhancements to the Hawaii Healthy Start and HFA models which are similar to elements included in the ABC/CalSAHF model (enhanced group/center-based program; addition of a nurse and substance abuse specialist to the multidisciplinary team; and elaboration of the multidisciplinary team). The site meets HFA accreditation criteria, but has chosen not to become an accredited HFA site.

Program Goals:

- Improved maternal life course
- Reduced risk for child abuse and neglect
- Families more effectively tied to other needed community services
- Reduced incidence of child abuse and neglect
- Improved child health and development outcomes

Time: November 1995-March 2000.

Population: screening of all new mothers at the Sharp Mary Birch Hospital (first by casefiles and then, if warranted, through in-person interview). If families were "overburdened", they were eligible for the study, so long as they could speak English or Spanish, were not active Child Protective Services cases, and did not live in regions of San Diego County where existing paraprofessional home visiting programs were in place. A total of 488 families were randomly assigned to either control or experimental group. Over both groups, 17% of families were Hispanic (English-speaking); 19% were Hispanic (Spanish-speaking); 24% Caucasian; 20% African-American; and 10% Asian/other. Over 55% received AFDC/TANF benefits at baseline. 49% manifested symptoms of clinical depression; 71% were covered by MediCal at baseline.

Evaluation: randomized trial

Period of follow-up: Baseline, and then every four months until end of services (when child was 3 years of age). Measures included phone contacts and annual in-person assessments of mothers and children.

Services: Contact with families was initiated in the hospital with a "welcome baby" gift. Families screened as high-risk were offered program services, which consisted of home visits, support groups and parenting classes, and case management. Parent support groups and parenting skills classes were offered alternatively every week, with transportation and child care provided. Child development specialists assessed children, offered assistance, and made referrals for additional evaluations, if needed. Control group families received a list of community resources at baseline.

Staffing: Paraprofessional home visitors, defined as bachelor's degree preferred, AA with experience considered; some college level coursework in child development, mental health, or related field, or at least 4 years of experience working with at-risk families. Knowledge of child abuse and child abuse reporting procedures; strong written, verbal and problem-solving skills; ability to engage resistant clients; strong background in child development, substance abuse, domestic violence, and family dynamics. 40-hour training, offered by the Family Stress Center, the principal trainers for Hawaii's Healthy Start program, before services began, and then ongoing training. Each team member received 1-2 hours of formal, weekly individual supervision. Caseloads of no more than 25/visitor.

Onset and Duration of services: Birth to age 3.

Frequency: initially weekly, fading over time.

Curriculum: Home visits included parent support, informal counseling, modeling and education regarding life skills, household management, child development and child management, linkages with community resources including physicians, as well as public service programs and assistance with transportation.

Results – Outcomes:

- At 36 months, visited families were less likely to report repeat pregnancies (49% versus 40%, p=.05). This difference was significant for white women, but not for women of other racial or ethnic groups.
- There was a trend for visited families to have fewer live births (28.6% vs. 22%, p=.09).
- No differences on measures of maternal substance abuse, being a victim of partner violence, confidence in adult relationships, mental health scores, or measures of social support at year 3, though visited mothers had shown less depressive symptoms than control group mothers at year 2.
- No differences in high school degree or employment levels, though visited mothers were more likely to have attended school (37% versus 28%, p=.05) at year 3.
- No differences in the home environment, mother-child interactions, use of non-violent discipline, or less stress related to parenting.
- Child abuse and neglect was assessed using a self-report measure of neglectful, psychologically aggressive and abusive behaviors. No differences in being likely to engage in neglectful behavior, to inflict corporal punishment, or engage in physical assault during the target child's first three years of life. However, visited mothers were less likely to engage in psychological aggression at year 2, and, for those mothers who did report they used psychological aggression or corporal punishment, the mothers in the control group used those techniques more frequently than the intervention group.
- No differences in percentage of children with health insurance; with a medical home; in immunizations; or in use of safety measures in the home; but children in the intervention group had more well-child visits in the second year of life.

- No differences in use of other services such as legal assistance, child care, respite care, transportation, adult education, housing, counseling, substance-abuse treatment, support groups, women's shelter, material assistance, and financial assistance.
- No difference in children's cognitive development at year 3, although intervention group children outperformed the control group in years 1 and 2.
- No differences in mothers' reports about children's behavior, except intervention group families reported fewer somatic problems at year 3.

Results – Process:

- Turnover in staff: 7/10 home visitors left during the project; all team leaders and their replacements left the program prior to completion
- About 70% of families who were screened eligible agreed to participate.
- Average of 43 home visits completed over three years, with the mean number of visits dropping from 20 in Year 1, to 13 in Year 2, to 10 in Year 3.
- 70% of families received at least some home visits each month over the first year, dropping to 50% by the last year.
- 30.5% of the families were not engaged in the program by the 20-month point (including 5.3% of families who moved out of the area)

APPENDIX C.
NATIONAL MODELS OF HOME VISITING PROGRAMS

CONTENTS

I. INTRODUCTION AND MAIN POINTS

A small group of national home visiting programs constitute or have influenced the development of most home visiting programs throughout the country. This Appendix offers a detailed description of each of these six large, national home visiting models, as well as a description of an exemplary California site for each model.

The six national program models include the following:

- *Early Head Start*, a federal program that focuses on providing children from low income families with the best possible start in life through center-based services, home-based services, or a combination of the two
- *Healthy Families America (HFA)*, evolved from Hawaii's Healthy Start program, utilizes a strength-based approach to provide voluntary services to overburdened families at risk for child abuse and neglect
- *Home Instruction for Parents of Preschool Youngsters (HIPPY)*, which seeks to help parents prepare their 3- to 5-year-olds for success in school
- *Nurse-Family Partnership (NFP)*, formerly the Nurse Home Visitation Program, developed as a university-based demonstration program in Elmira, New York, studied again in Memphis, Tennessee and Denver, Colorado, and now being replicated nationally; uses nurses to deliver home visits to pregnant and parenting, low-income, first-time mothers
- *Parents As Teachers (PAT)*, a program that began in Missouri and, as of February 2002, operated in more than 2,879 sites across the country to promote the development of children from birth to five
- *Parent-Child Home Program (PCHP)*, formerly the Mother-Child Home Program, developed in the 1960s and now replicated nationally, to strengthen parent-child verbal interaction in families with 2- and 3-year-olds and to prepare children for school and to achieve long-term academic success

Together, these programs operate at thousands of sites across the country and serve hundreds of thousands of children. With the exceptions of Early Head Start and PAT, however, these programs have not made as much headway into California as they have in other states. In California, home-grown models such as Cal-SAHF and Answers Benefiting Children (ABC) were created. Nevertheless, the national models have influenced the programs that are here. Indeed, Cal-SAHF and ABC evolved from Healthy Families America. And, these national models are the programs that communities are likely to consider first when they think about launching a home visiting program.

The following describes each of the national models, highlights a California program site (recommended as exemplary by the national office of the program model), and provides contact information. In addition, the Sacramento County Birth & Beyond program is profiled as an example of a Cal-SAHF/ABC program site.

The profiles of the California programs suggest the following main points:

1. *Staffing*: The programs employ different staffing constellations, including paraprofessionals (HIPPY, PCHP), AmeriCorps members (Birth & Beyond), individuals with bachelors and masters degrees in early childhood or social work, nurses (NFP), and combinations of individuals with varying levels of training and education.

2. *Families served*: The families served reflect the remarkable diversity in California, and include Latinos, African-Americans, Asian-Americans, Native Americans, and white non-Hispanic families. Immigrants from countries such as Mexico, Guatemala, El Salvador, Belize, Panama, Peru, Somalia, Cambodia, and Laos all participate. Serving the diverse cultures strains the abilities of programs to hire appropriate staff and provide appropriate materials.

3. *Caseloads*: Home visitors vary in the numbers of families they serve, ranging from 10 to 25, depending upon the intensity of the home visit schedule. With the exception of Birth & Beyond in Sacramento, which serves about 900 families at any one time, the highlighted programs are small, discrete efforts, which have the capacity to serve from 75 – 250 families at any one time.

4. *Linkages with service systems*: The highlighted programs illustrate some interesting connections with various service systems. The National City PAT program, for example, is administered by a school district in partnership with a family resource center. Other programs operate out of hospitals (PCHP) or in conjunction with health departments (NFP). Perhaps the most comprehensive site is the Hope Street Family Center Early Head Start program, which has linkages with Even Start, a youth center, a continuation high school operated in collaboration with the Los Angeles Unified School District, an extended family child care network, and health and nutrition services for child and parent.

5. *Service modifications and additions*. Each program site has developed some adaptations to the basic home visiting model. For example, home visitors in the Homeys HIPPY program in San Diego now assess the health of the child, in addition to providing the standard HIPPY curriculum. The National City PAT program is piloting the use of a special PAT curriculum with kith and kin child care providers. The Fresno NFP program has added a mental health component and Mommy and Me playgroup. Each modification was developed to respond to community needs, and each extends the reach of the program.

6. *Evaluation, Quality Assurance, and Quality Improvement*: Most sites employ one or more approaches to determine if they are meeting their programmatic goals or performance standards. These include comparing their own performance against standards established by the national program offices (Early Head Start), providing data to the national program offices for feedback and comparison with other sites (Nurse-Family Partnership), and seeking accreditation (Healthy Families America) through systems established by the national program offices.

7. *Budgets and Funding*: Annual costs per family for home visiting vary, ranging from about $1,200 (National City PAT) to about $11,500 (Hope Street EHS) per family. Funding sources include U.S. Department of Health and Human Services (Head Start), U.S. Department of Education, California Department of Education, local city and county funding, First 5 dollars, private foundations and corporations, Title I, Even Start, EPSDT, and Medicaid dollars. (For additional information about funding home visiting programs, see Appendix E (FAQ8): How Much Does Home Visiting Cost, and How Can We Pay for Services?)

8. *Challenges Faced*: Despite the differences across programs, the challenges that the sites report are fairly similar. Many program administrators mentioned how difficult it has been to hire and retain good home visitors, especially visitors who reflect the diversity of the families served. They struggle to retain families that they serve, and some programs have begun to offer tangible incentives (e.g., raffles for electronic equipment) to encourage families to remain in the program. Finally, program administrators mention the continual struggle to secure steady, ongoing funding for program services.

Appendix C-1
Early Head Start

The National View

Early Head Start (EHS) was established in 1994, when the Head Start Authorization Act of 1994 mandated new Head Start services for families with infants and toddlers. A total of 3 percent of the Head Start budget was earmarked for infants and toddlers, a percentage that climbed to 10% by 2002. The total budget for EHS for 2002 was $640 million.

The first 68 EHS grantees were funded in September 1995. By 2002, some 45,000 children were served through 664 EHS programs, including 53 programs in California.

Early Head Start programs are comprehensive, "two-generation" programs that seek to produce outcomes for children and parents. EHS addresses four main domains:

- *Children's development*: including health, resiliency, social competence, and cognitive and language development
- *Family development*: parenting and relationships with children, the home environment and family functioning, family health, parent involvement, and economic self-sufficiency
- *Staff development*: professional development and relationships with parents
- *Community development*: enhanced child care quality, community collaboration, and integration of services to support families with young children

Early Head Start serves low-income pregnant women and families with infants and toddlers. Most families must have incomes at or below the federal poverty level or be eligible for public assistance, although 10% of children may be from families that exceed these income eligibility criteria. Programs must reserve at least 10 percent of their spaces for children with disabilities.

Program services include early education both in and out of the home; parenting education; comprehensive health and mental health services, including services to women before, during, and after pregnancy; nutrition education; and family support services.

Early Head Start: Key Features

- 664 programs nationally; 53 in California (as of Feb. 2002)
- Services to parents and children
- Center- and home-based
- National training and technical assistance network
- Performance standards developed
- Large, national evaluation (See Appendix B.)

Programs may offer these services through primarily center- or home-based strategies, or through a combination of approaches. Each program component must meet Early Head Start performance standards, and programs are visited every three years to determine if they are in compliance with program guidelines. In home-based programs, home visits are scheduled weekly and are complemented by group socialization opportunities, scheduled biweekly. Home visitors need not have any special training or background.

A network of training and technical assistance supports EHS sites. The Early Head Start National Resource Center provides ongoing support, training, and technical assistance under a contract with the organization Zero to Three, and in conjunction with the Head Start Quality Improvement Centers and the Head Start Disabilities Services quality Improvement Centers.

Head Start programs are required to involve parents and community representatives in all areas of the program, including policy, program design, curriculum, and management decisions.

The California View: The Hope Street Family Center Home Visitation Program

The Hope Street Family Center Early Head Start program is part of a national effort to promote the overall health, social, emotional, cognitive, and physical development of children, 0 to 3 years of age, while simultaneously enhancing family self-sufficiency and the capacity of families to nurture and care for their young children.

Context of Home Visiting Services

Established in 1992 as a collaboration between the University of California, Los Angeles, and California Hospital Medical Center, the Hope Street Family Center is a comprehensive family resource center, providing an array of health, early childhood education, parenting, child care, adult education, and social services for low-income families living in the neighborhoods of central Los Angeles. Through **Early Head Start**, one of the Center's core programs, families with children 0-3 years of age participate in weekly home-based early childhood education and family development activities. A key feature of the Hope Street Early Head Start home visitation model is its articulation and co-location with other family support services. This includes the **Home Visitation Expansion Project** which extends home-based early childhood education services to families with children 3-5 years of age, and the **Even Start Family Literacy** program, which provides literacy and adult education services for Early Head Start parents, while simultaneously offering daily center-based early childhood education and parent education opportunities. For school-aged siblings of Early Head Start children, the **Hope Street Youth Center** offers mentoring, homework assistance, computer training, and after-school recreational activities; the **Continuation High School** program, operated in collaboration with the Los Angeles Unified School District, offers high-school instruction for at-risk siblings and pregnant and parenting teens. The **Extended Day Family Child Care Network** offers developmentally enriched child care for Early Head Start children whose parents are working and/or studying. The **Language Enhancement Training Project** teaches child care providers and home visitors how to foster the emerging language skills of infants and toddlers. Special supports for families impacted by family violence are offered through the Center's **Pico-**

Early Head Start at Hope Street: Key Features

- Family resource center, home-based, and center-based services
- Father and sibling involvement
- Ongoing program evaluation and continuous quality improvement
- 120 families in home visiting caseload
- $4.5 million annual budget (total Hope Street budget in 2001)
- $11,500 per family per year for home visiting and ancillary services

Union Family Preservation Network, which provides intensive child welfare services for families impacted by child abuse and neglect. Finally, the co-location of Early Head Start services with **primary health and nutrition services** provides ready access to WIC, prenatal care, well-child care, immunizations, adult ambulatory care, and family planning services.

Families Served

The target population for Early Head Start home visitation services includes pregnant women, infants, toddlers, and their families, who meet federal low-income guidelines, and live within the service area of central Los Angeles.

The Hope Street Family Center targets a population of nearly 500,000 residents, one-third of whom are under 17 years of age, with 10% four years of age or younger. Poverty, high unemployment and underemployment, substandard housing, limited English proficiency, low literacy, and lack of access to health and social services are among the issues impacting the families and communities served by the center.

The Early Head Start referral network includes local health care, social service, and child welfare agencies; schools and other educational institutions; churches; WIC sites; and programs serving children with disabilities. However, current and former parents provide the largest number of referrals. Parents generated over one-third of program referrals in 2001.

The population served in 2001 was 94% Latino, 5% African-American, and l% Asian-American. Families were predominantly mono-lingual Spanish-speaking, recent immigrants (arriving within the last 7 years) from Mexico and Central America. The program serves the working poor. Although one or both parents were employed on a full-time basis in 76% of families, the annual family income for 64% of families was under $15,000. The program maintains a minimum disability enrollment of 10%. Current disabilities enrollment is 18% and includes children with mild to severe developmental delays, chronic medical conditions, and children who are equipment dependant.

Intensity of Home Visits

The home visitation model employed by Hope Street uses a combination in-home and center-based design that is flexible, fluid, and responsive to the changing circumstances of individual families. Home visitation options include (a) weekly home visits, with each visit lasting approximately 90 minutes; (b) weekly or biweekly home visits coupled with center-based activities for parents and children, one to five times per week; and (c) weekly or bi-weekly home visits concurrent with daily center-based early childhood education services. These various options offer parents choices as family needs and circumstances change over time. For example, a family may participate in home visitation services only during the prenatal period or immediately after the child's birth. When the child is older or as parents return to work or school, the family may opt to participate in a combination of center- and home-based services.

Home visitation services are provided within an ecologic framework that considers the needs of the child as well as the needs and resources of the child's family and community. Services are designed to be comprehensive, continuous, and family-focused. They typically begin prenatally and extend through the child's third year of life.

Caseloads
Home visit caseloads average 10-12 families per home visitor.

Service Array
Home visitation activities typically fall into the broad categories of early childhood education, parenting education, health education and anticipatory guidance, and case management/family support services.

Center-based services include a family literacy program; English as a Second Language (ESL) classes; continuation high school coursework leading to a high school diploma; parenting education classes; infant, toddler and preschool early childhood education classes; full-day child care; and Mommy and Me or Daddy and Me socialization play groups. Additional center-based services include family field trips, camping opportunities for parents and children, and a program of structured after-school mentoring and recreational activities for school-aged siblings.

Currently (in 2002), the program serves 120 children, of whom 28% receive weekly home visitation services; 28% of children receive biweekly home visits and participate in daily center-based early childhood education activities. Fully 42% of children are in licensed child care settings and therefore receive biweekly home visits, along with biweekly visits at the child care setting, with both parent and provider present.

Staff Qualifications
Qualities and characteristics used to guide staff hiring include: (a) linguistic and cultural competence, (b) an understanding of how to serve young children within the context of their family, (c) experience in providing home-based services, and (d) a willingness to acquire new skills and expand one's area of expertise. Home visitors are required to have a minimum of a bachelors degree in the areas of early childhood education, social work, psychology, nursing, or a related field. The program also utilizes a supervisory team with masters degrees in psychology, social work, early childhood education, and nursing. This mix of backgrounds and areas of clinical expertise encourages staff to employ multidisciplinary approaches in planning, developing, and implementing home visitation services.

Standardized Curriculum
The home visitation program utilizes a locally developed curriculum that draws heavily upon the Partners in Parenting (PIPE) and Creative Curriculum (Trister-Dodge). The content of the home visit is the result of weekly planning between the parent and the home visitor and is based upon an assessment of family interests, needs, and strengths in the areas of health and nutrition, child development and parenting, education and

training, family relationships and community supports, and the physical home environment.

Special Outreach
Many of the fathers in the families who receive home visitation services are working and unable to participate in home visits conducted during the day. Through the Daddy and Me playgroups and special Saturday activities, the program makes a special effort to ensure that fathers have opportunities to spend time with their young children, in ways that strengthen the development of healthy, positive relationships.

Educational, health care, and recreational services are also offered for school-aged siblings and for the "graduates" of the home visitation program. These services support the foundation for school readiness that was laid down during the pre-school years and help insure children's continued academic success.

Integration and Coordinating Funding
The Hope Street Family Center is supported by funds from the U.S. Department of Health and Human Services, Head Start Bureau; California Department of Education; City of Los Angeles; Los Angeles County Children and Families First, First 5 Commission; California Hospital Medical Center Foundation; UniHealth Foundation; Catholic Healthcare West Southern California; and a variety of private donors and foundations. The program budget in 2001 was approximately $4.5 million for all Hope Street services.

Linkages with the Service System
The Hope Street Family Center is active in a broad array of community collaboratives and service provider networks. In addition, the Center has entered into formal partnerships that include shared resources (facilities, staff, and finances) with the Los Angeles Unified School District, Los Angeles County Department of Health Services, and Los Angeles City College

Program Evaluation and Continuous Quality Improvement
The extent to which the program model is implemented and the extent to which parents and children are participating in program services is monitored through regular review of MIS data and reports, weekly case conferences, monthly chart audits, weekly individual supervision and case discussions, and regular joint home visits.

In addition, the Hope Street Family Center's evaluation and continuous quality improvement plans utilizes information gathered from MIS statistics, community assessment data, parent surveys and focus group interviews, staff surveys and focus group interviews, community focus group interviews, observational assessments, and clinical case reviews and chart audits as the basis for short and long-term program evaluation, development and planning activities. Extensive program and fiscal audits are conducted on an annual basis by an independent evaluation consultant and at least every three years by a monitoring team representing the principal funding agency.

Data collected as part of these quality improvement and program evaluation activities indicate the following:

- During 2001, 36% of children exited the program for several reasons, many of which could be judged as evidence of program success:
  - Child's graduation from Early Head Start (16%)
  - Family relocation outside the service area (8%)
  - Parent secured employment that prevented participation in home visitation (2%)
  - Parent withdrawal from the program (10% -- which is the level which the program sets as its target maximum level for this category of "attrition")
- Over the last five quarters, home visit completion rates ranged from 62% to 81%.
- The program's 12 home visitors have been employed with the program an average of 3.4 years (range of .5 – 8.5 years).
- For those parents who are participating in home visits twice per month, center-based child development, and family literacy services:
  - 77% received 60% or more of possible English as a Second Language instruction
  - 61% received 60% or more of possible parenting education hours of instruction
  - 70% of parents and children participated in 60% or more of possible parent-and-child-together hours within the early childhood classroom.
- At the end of 2000, over 51% of participating households had one or both parents attending a training program or in school.
- 92% of participating children were up-to-date on their immunizations
- 94% of participating children had a well-child exam within the year
- 100% of pregnant women were enrolled in prenatal care

Lessons Learned/What Seems Important

Staff of the Hope Street Family Center identify the following elements as crucial to program success:

- Staffing
  - Stable leadership with clear programmatic vision: The executive director, director, and four area coordinators average 8 years tenure with the program.
  - Excellent staff: hiring a staff that is well-prepared, clinically excellent, with an appreciation for multi-disciplinary work, culturally competent, committed to the population being served, respectful of families, and able to form relationships
  - Emotional support for staff: providing staff supervision that is collaborative and solution-focused, paralleling the therapeutic approach in working with families
- Service Content and Connectedness
  - Home- and Center-based services: Both are required to make a difference in the development of children and to adequately address family/social issues
  - Community-driven and connected: services need to be developed in response to needs identified by the community. An orrganic, developmental approach

to program development creates community buy-in and helps with sustainability
  - Family-focused services, with special emphasis on fathers and siblings. Outcomes for children are determined by multiple factors within the family and the home environment. Fathers and siblings are a huge part of the puzzle.
- Evaluation and data: Build a solid MIS system for day-to-day program management, program compliance, and tracking outcomes, and then select a few key indicators and track them carefully.
- University Affiliation: the connection with UCLA enriches staff, brings resources to the community, and supports the training and technical assistance needs of the program
- Size: Because Hope Street is still a relatively small program, program staff can know and remember the families who are served. In a program such as this, where relationships are central to program success, this is a critical element, especially for the families served, who may feel anonymous and unimportant in the wider community.
- Quality facilities, staff, and services: The presence of a top-notch program demonstrates to families that they are valued, and it de-stigmatizes services.

Challenges

Staff note several challenges, faced by many home visiting programs:

- Fragmented funding: Managing multiple grants, with differing reporting requirements and compliance requirements, evaluation needs, and reporting schedules is a challenge.
- Staffing:
  - Finding staff with necessary skills and cultural competence.
  - Meeting the mental health and training needs of staff
- Developing an appropriate MIS program is time-consuming and challenging
- Simultaneously addressing children's developmental needs and the complex psycho-social needs of parents and families.

Contact Person:

Vickie Kropenske, PHN, MSN
Director, The Hope Street Family Center
California Medical Hospital
Los Angeles, California
kropensk@chw.edu
(213) 742-6385

Profile of the Hope Street Family Center Home adapted from: Thompson, L., Kropenske, V., Heinicke, C., Gomby, D., & Halfon, N. *Home Visiting: A Service Strategy to Deliver Proposition 10 Results*, in N. Halfon, E. Shulman, and M. Hochstein, eds., Building Community Systems for Young Children, UCLA Center for Healthier Children, Families and Communities, 2001. Available at http://healthychild.ucla.edu.

Early Head Start – California Sites*

Site Location & Initial Training Date	Contact Person	Phone Number	Email Address
Alturas (Modoc County Office of Education)	Jeri Standle	530-233-7159	jstandle@hdo.net
Arcata (North Coast Children's Services)	Siddiq Kilkenny	707-822-7206	siddiqk@ncsheadstart.org
Auburn (Placer Community Action Council, Inc.)	Dolores Garcia	530-886-4127	
Bakersfield (Ebony Counseling Center)	Christine King	661-324-4756	ecomm1937@ts.com
Bakersfield (Kern County Economic Opportunity Corporation)	Archie Catron	661-336-5236	
Beaumont (Child Help USA, Inc.)	Klara Pakozdi	909-845-0913	klarapakozdi@hotmail.com
Berkeley (Berkeley YMCA Early Head Start)	Mary Campbell	510-559-2090	
Cerritos (Los Angeles County Office of Education)	Andrew Kennedy	562-940-1770	
Colusa (Colusa County Office of Education)	Kathy Davidson	530-458-0300	kdavidson@colusa-coe.k12.ca.us
Concord (Contra Costa County Board of Supervisors)	Tony Colon	925-646-5990	
Fremont (Child, Family and Community Services, Inc.)	Hazel Knatt	510-796-9511	
Fresno (Fresno County EOC)	Kathleen Shivaprasad	559-263-1550	kseocehs@pacbell.net
Goleta (Community Action Commission of Santa Barbara County)	Giti Fatholahi	805-964-8857 x 154	fforman@cacsb.com
Handsford (Kings Community Action Organization)	Margaret Crawford	559-582-4386	vgonzales@kcao.org
Hoopa (Hoopa Valley Tribal Council)	Angel Korb	530-625-1022	angelrigilkorb@yahoo.com
Lakeport (Sutter Lakeside Community Service)	Kathy Lytle	707-262-1611	lytleck@sutterhealth.org
Los Angeles (Charles R. Drew University of Medicine and Science)	Linda Rahman	310-605-0164	
Los Angeles (Children's Institute International)	Manny Castinos	213-807-1925	calvarez@childrensinstitute.org
Los Angeles (El Nido Family Centers)	Emily Lloyd	213-384-1600	lloyd@elnidofamilycenters.org
Los Angeles (Hope Street Family Center)	Vickie Kropenske	213-742-6479	kropensk@chw.edu
Los Angeles (University of Southern California)	Lucia Palacios	213-743-2466	

Marysville (E-Center, Migrant Head Start)	Joanne Aiello	530-741-2995	
Modesto (Central California Migrant Head Start)	Deborah Clipper	209-558-4030	dclipper@stan-co.k12.ca.us
Novato (Community Action Marin Head Start)	Kay Wernert	415-883-3791	kay@marinheadstart.org
Oakland (City of Oakland)	Unsana Pulliman	510-238-3165	upolliam@oaklandnet.com
Oxnard (Child Development Resources of Ventura County, Inc.)	Reyna Dominguez	805-485-7878	alicia.ramirez@cdrofvtaco.org
Pasadena (Center for Community & Family Services)	Vassy Tesfa	626-583-1770	
Placerville (El Dorado County Office of Education)	Gail Healy	530-622-7130	ghealhy@edcoe.k12.ca.us
Redding (Shasta Head Start Child Development, Inc.)	Carla Clark	530-241-1036	carlac@shastaheadstart.org
Riverside (Riverside County Office of Education)	Margie Herrera	909-826-6614	mherrera@rcoe.k12.ca.us
Sacramento (Sacramento Employment and Training Agency)	Catherine Goins	916-263-3804	Catherine@headstart.seta.net
Salinas (Children's Services International)	Jean Miner	408-424-6939	
Salinas (Monterey County Office of Education)	Ricardo Tellez	831-755-0352	
San Diego (Neighborhood House Association)	Barbara Fielding	858-715-2642	barbara@neighborhoodhouse.org
San Jacinto (Ahmium Education, Inc.)	Ernie Salgado	909-654-2781	ernie@ivic.net
San Jose (Yolanda Garcia)	Santa Clara County Office of Education	408-453-6980	yolanda_garcia@sccoe.org
San Luis Obispo (Economic Opportunity Commission of San Luis Obispo County, Inc.)	William Castellanos	805-544-4355	
San Marcos (Metropolitan Area Advisory Committee Project)	Edna Holloway	760-471-4210	eholloway@maac.cc
Santa Ana (Orange County Head Start)	Adolfo Munoz	714-241-8920	
Santa Rosa (Sonoma County People for Economic Opportunity)	Ofelia Ochoa-Morris	707-544-6171	ofelia@scpeo.org
Sisma Hill (Long Beach Unified School District)	Gwendolyn Matthews	562-427-0833	gmatthews@lbusd.k12.ca.us
South San Francisco (The Institute for Human and Social Development)	Amy Liew	650-871-2690	a.liew@ihsdmc.com
Stockton (County of San Joaquin)	Marci Massei	209-466-5541	marcima@hscdc.org
Ukiah (E-Center)	Thomas Wagner	707-468-0194	

Ukiah (North Coast Opportunities, Inc.)	Corrine Lindgren	707-462-3403	ncohdst@pacific.net
Valley Springs (Human Resources Council, Inc.)	Lin Reed	209-772-3980	karenp@volcano.net
Van Nuys (Easter Seals Southern California, Inc.)	Carlene Holden Sr.	818-996-9902	
Venice (Venice Family Clinic)	Manuel Castellanos	310-392-8630	
Visalia (Tulare County Office of Education)	Senaida Garcia	559-651-3022	sgarcia@cc.tcoe.org
Watsonville (Santa Cruz Community Counseling Center, Inc.)	Pam Elders	831-688-8100	sccohs@cruzio.com
Woodland (California Human Development Corporation)	Judy Tischer	707-523-1155	j.tischer@chdcorp.org

*Source: http://www.ehsnrc.org/ProgramLocator/reglist.cfm (as of 1/2003)

Appendix C-2
Healthy Families America

The National View

In 1992, the organization then known as National Committee to Prevent Child Abuse – now known as Prevent Child Abuse America (PCA America) – launched Healthy Families America (HFA), an initiative to provide voluntary home visitation services for new families at greater risk for parenting problems, including child abuse and neglect. HFA programs now serve more than 66,000 families in more than 450 geographically and culturally diverse communities in 39 states, the District of Columbia, and Canada. Indiana has the most HFA sites, with services in all 92 counties. Other major initiatives are under way in Arizona, Florida, Georgia, Illinois, New York, Massachusetts, Michigan, Virginia, and Washington, D.C.. In 2002, California had two HFA sites.

HFA's goals are to promote positive parenting, enhance child health and development, and prevent child abuse and neglect by enhancing parent-child interaction, promoting the use of community resources, and creating community systems of support to assist parents in caring for their newborns.

Systematic assessment of all families in an intended population within a community is a distinguishing feature of HFA. More than 90% of all HFA programs reach out to either all new parents or all first-time parents within a community. Assessment usually occurs in the hospital or home with a specially trained person who listens to the family's interests and concerns and links the family with appropriate community resources.

Families at greater risk of parenting difficulties are encouraged to participate in home visiting, beginning with weekly visits. Visit frequency is reduced as families meet specific goals, which they develop with their home visitors during the initial visits. Services begin at a child's birth (or during pregnancy) and can continue until the child is five years of age.

Healthy Families America: Key Features

- 450 sites nationally; 2 in California (as of 2002)
- Evolved from Hawaii Healthy Start as child abuse prevention program
- Basis for Cal-SAHF/ABC programs
- Originally, paraprofessional model; increasingly, professional staff used
- Programs required to have 12 critical elements
- Quality assurance via credentialing process with national credentialing body (Council on Accreditation of Services to Families and Children)

Home visitors are selected on the basis of personal characteristics rather than formal education. The most important criterion is the ability to engage families and establish trusting relationships. Most HFA home visitors (82%) attended or graduated from college, specializing in child development, social work, nursing, or education. Most (87%) also have prior experience in home visitation programs.

Although initially guided by the Hawaii Healthy Start Program and other major family support initiatives, HFA is not a strict replication model. Flexibility is essential to allow implementation in a wide range of communities. For example, each HFA program must

systematically assess all families in its intended service population, but each community defines its intended population (for example, first-time parents, or all families living in selected neighborhoods).

To ensure quality with flexibility, HFA's home visitation effort is defined by 12 critical elements, which are based upon two decades of research regarding best practice standards. In partnership with the Council on Accreditation of Services to Families and Children (COA), PCA America developed and implemented a credentialing process to document that each HFA program adheres to the critical elements.

The average annual cost per family for HFA services typically ranges from $3,000 - $5,000. In 2000, the average program budget was $495,000. Most HFA program sites have multiple funding sources which include the following: local charities; foundations, TANF; the Family Preservation and Support Act; Children's Trust Funds; Maternal and Child Health Services Block Grant (Title V); Early Intervention, Part H/C; Medicaid; and the Office of Juvenile Justice and Delinquency Prevention.

PCA America serves as the national headquarters for HFA, and credentials programs, trains and certifies HFA trainers, provides individualized technical assistance and written materials to state and community HFA leaders, conducts and coordinates research on HFA, and hosts national HFA conferences. PCA America also links evaluation research with practice by convening the HFA Research Network to analyze program evaluations and design issues.

The California View: Healthy Homes in Lancaster, California

In 2002, two HFA programs operated in California. The Healthy Homes program in Lancaster is administered by Antelope Valley Hospital, and serves both urban and rural families throughout the Antelope Valley, the northernmost area in Los Angeles county, located about 65 miles north of the city.

The Healthy Homes program was established in July 1998, driven by the hospital's desire to address the very high rates of child abuse and neglect and of child deaths in the community. The hospital's CEO sent a team to Hawaii to learn about its Healthy Start program, was persuaded that the program held great promise for the Antelope Valley, and soon thereafter, the program in Antelope Valley began, with initial funding from the hospital.

The HFA Healthy Homes Program: Key Features

- Hospital-administered
- Rural and urban families
- 100% of families at initial screening have had mental health issues
- Trying to use tangible incentives to retain families
- Strong staff support
- 91 families
- $860,000 budget

Program Services

Two assessment workers screen families at-birth at the hospital, which is the only birthing hospital in the area. A full-time registered nurse provides a two-hour home visit with each family that is screened eligible for the program. During the visit, the nurse provides education and instruction on caring for the baby, feeding, breastfeeding smoking cessation, and health

issues for both the mother and the baby. The nurse remains available to the program, conducts a home visit after any hospitalization, tracks immunizations, and trains the staff.

During visits, home visitors pay attention to both the needs of the mother and of the child. The Ages and Stages Questionnaire is used to screen children, the Portage guide is employed, and the HELP parenting guide from Hawaii is used to promote child development. The program has MOUs with 15 local agencies for training and regularly makes referrals to other agencies, especially to mental health services in the community.

Staffing and Caseloads

Fully 89% of families offered intensive home visiting accept it. The more intensive home visits are provided by eight home visitors. Each home visitor carries a caseload of 10-12 families. In keeping with the HFA model, home visitors have a high school diploma, and A.A. or B.A. degrees are optional. Personal characteristics receive the highest priority in hiring, although most visitors do have some background in a related field. A marriage and family therapist is also available 5 hours per week to assist with mental health issues that the families may have.

Families Served

Since the inception of the program, 342 families have been served, and the current (in 2002) caseload is 91 families. Eligible participants include women of child-bearing age, either pregnant or with new-borns, who live within the geographic cachement area, and screen positive on the Kempe Family Stress Checklist. Families are from many backgrounds: about 43% of families are Hispanic, 20% African American, and most of the rest are white. Fully 100% of families had a mental health issue upon screening, whether that was a confirmed diagnosis, depression, or suicidal ideation. All of the families have household incomes of 200% of poverty or less.

Funding Sources

Since its inception, the program has received funding from public sources, such as Los Angeles County and the City of Palmdale, and private dollars from foundations such as The California Endowment and Freddie Mac, and corporations such as Boeing and Northrop. The annual program budget is about $860,000.

Evaluation and Quality Improvement

In 2002, the program applied for credentialing through HFA, and collected some information about program performance as part of that process. For example, since the program's inception, about 75% of families remained in the program for longer than 6 months, and about 30% of families remained in the program for longer than 2 years. Families averaged about 3.2 visits per month, including the initial visit from the nurse. All the 2-year-olds in the program were fully immunized. Fully 93% of enrolled mothers delayed a subsequent pregnancy to work or go to school. As of March 2001, 80% of mothers were in school, job training, or were employed. Only 3.5% of the families had open cases of child abuse and neglect.

Challenges and Next Steps

As is true for most of these programs, the challenges facing the program include raising dollars to keep the program running. Other challenges include retaining staff and keeping families engaged. The program actively works to nurture the staff, both to model for the staff the relationship to have with families, and also to foster a warm and supportive working environment to help retain staff. Activities for staff include stress reduction, periodic celebrations and breakfasts. To help retain families, the program has begun to offer tangible benefits for participants such as infant thermometers, smoke alarms, and a semi-annual drawing for an attractive electronic product such as a television or VCR.

Transportation remains a significant problem for families, and the program is pursuing an opportunity to partner with a local church, whereby church members will volunteer to help transport families to appointments.

For more information about operating an HFA program in California, contact:

Lea Butterfield at 661-726-6450
Cydney Wessel at the national office (312-663-3520).

For more information about HFA research or program evaluation, contact:

Kathryn Harding or Lori Friedman at the national office
200 S. Michigan Avenue
Suite 1700
Chicago, IL 60604
(312) 663-3520

Healthy Families America – California Sites

Site Location & Initial Affiliation Date	Contact Person	Phone Number	Email Address
Lancaster (Healthy Homes); July 1998	Lea Butterfield	661-726-6450	lea.butterfield@avhospital.org
Sacramento, Placer, Yolo, Amador, Nevada, and San Joaquin counties (Creating Healthy Environments for Children (CHEC), Sutter Medical Center) September 1997	Arlene Cullum	916-733-8442	culluma@sutterhealth.org

Appendix C-3
Home Instruction for Parents of Preschool Youngsters (HIPPY)

The National View

The Home Instruction for Parents of Preschool Youngsters (HIPPY) program aims to maximize children's chances for successful early school experiences by empowering parents as primary educators of their children and fostering parent involvement in school and community life. HIPPY USA supports the development and operation of HIPPY programs in communities across the United States through ongoing curriculum development and technical assistance.

HIPPY was developed in Israel in 1969, and the first HIPPY programs were established in the United States in 1984. In 2002, 160 HIPPY programs served more than 16,000 families in 27 states, plus the District of Columbia and Guam. There were 11 HIPPY sites in California in 2002. Participating families are a richly multiethnic, multilinguistic group, primarily low-income, and living in wide-ranging urban, suburban, and rural environments.

HIPPY in the United States was a two-year program for parents of children ages four and five until 1994, when HIPPY USA introduced a new curriculum for three-year-olds, offering U.S. HIPPY programs the option of operating as either two- or three-year programs. The HIPPY curriculum focuses on the development of cognitive skills, including language development, problem solving, logical thinking, and perceptual skills. The curriculum also fosters the development of social/emotional and fine and gross motor skills.

HIPPY activities are written in a structured format, comparable to a well-designed lesson plan for a novice teacher. Available in English and Spanish, the curriculum contains 30 weekly activity packets, nine story books, and a set of 20 manipulative shapes for each year. Skills and concepts are developed through activities such as reading, writing, drawing, listening, talking, singing, playing games, puppetry, cooking, sewing, poetry, movement, and finger plays.

HIPPY: Key Features

- 160 sites; 11 in California (as of 2002)
- Paraprofessional home visitors
- Serves families with 3-5-year-olds
- Home visits and parent group meetings
- Curriculum available in Spanish and English; Chinese and Native Hawaiian forthcoming
- Focus on promoting child development by empowering parents to be the primary educators for their children

Parents are trained to use the curriculum through weekly visits with paraprofessionals who are also parents in the program. Every other week (or at least 15 times per year), the home visitors role-play the activities with parents during visits that each last at least 30 minutes each. On alternate weeks, all of the parents and home visitors meet at the HIPPY site to role-play the activities as a group.

HIPPY home visitors are members of the participating communities and are themselves

parents in the program. Home visitors have typically obtained a high school or equivalency diploma, and receive both intensive initial training and ongoing weekly training.

Each HIPPY program is supervised by a professional coordinator, typically an individual with a background in early childhood education or social work, who recruits parents, hires and trains paraprofessional home visitors, organizes parent group meetings, and ensures that families are linked to other services in the community. The coordinator and the paraprofessionals meet weekly to role-play the materials, discuss the previous week's activities, share experiences, solve problems, and also develop individual career-development plans for the paraprofessionals.

The HIPPY model has been adapted to meet societal changes and local community needs. For example, HIPPY has responded to the work requirements imposed on families by welfare reform with evening and weekend home visits, lunch hour visits at the workplace, or after-work visits at the child care center. Some HIPPY programs employ a schedule of weekly home visits and monthly group meetings to reach families that live in remote locations.

Local HIPPY programs are funded through many private and public sources, including the U.S. Departments of Education, health and Human Services, and Housing and Urban Development; federal community service programs such as AmeriCorps and Volunteers in Service to America (VISTA); federal and state job training and early intervention/prevention programs; and foundations and corporations. Collaboration with such programs as Head Start and Even Start ensures broader services to families and maximizes funding and other resources. The average annual cost per family was $1,200 in 1999-2000. Average program site budgets were about $180,000.

HIPPY USA provides each HIPPY program with intensive preservice training, comprehensive training guides for both program coordinators and home visitors, annual site visits with on-site training, an annual national conference, a newsletter published three times each year, and ongoing telephone support. HIPPY programs participate in a biannual self-assessment and validation process. They submit to HIPPY USA demographic information on program participants annually for analysis and dissemination.

HIPPY USA conducts ongoing curriculum development to ensure that all materials are developmentally appropriate, culturally relevant, and reflective of the growth that occurs in children and parents as they progress through the program. Recent revisions and additions to the curriculum include revised curricula for ages four and five; parent materials, including enrichment guides for families who want or need more practice in certain areas; a home visitor guide; and a nutrition curriculum (in collaboration with the Center on Hunger, Poverty and Nutrition Policy at Tufts University). A revision of the age-three curriculum should be complete in fall 2002. A translation of the curriculum into Chinese will be available in fall 2002, and a translation into native Hawaiian is planned.

The California View: The Homeys Youth Foundation Program

In 2002, 11 HIPPY programs operated in California with funding from private foundations and public sources such as the California Department of Education, Title I, the U.S. Department of Education, Even Start, and First 5. A total of $1 million in California Department of Education funds are earmarked for HIPPY. The 11 programs have the capacity to serve close to 1,000 families.

California State HIPPY Office

One of the largest programs is administered by the Homeys Youth Foundation in San Diego, which also serves as the state office for HIPPY in California. The state office is guided by a statewide advisory committee comprised of community leaders, school administrators, and civic and business leaders from throughout California. The state office provides training and technical assistance to all HIPPY sites in the state, and to new sites that are seeking to begin programs. It also produces a state-wide HIPPY newsletter, performs a self-assessment or annual review of HIPPY programs in the state, organizes an annual conference, supports local grant writing efforts, and helps train local sites on the use of the HIPPY management information system.

The San Diego program is also an excellent example of a HIPPY program. Established in 1994, the program was originally funded by the San Diego Unified School District and the Jacobs Family Foundation to provide services for 45 families and children. Clinton Pearson, a resident of the community being served by the program, sought the support of local chapters of the National Council of Jewish Women (the organization that helped bring HIPPY to the United States from Israel) to help launch HIPPY in his community, both because of the program's focus on child development and because of its focus on community development and the development of its paraprofessional home visitors. San Diego HIPPY was the second HIPPY site in California (after the Long Beach program).

Funding Sources

The San Diego program has been supported over the years by funds from the San Diego Unified School District, City of San Diego, Weingart Foundation, San Diego Foundation, Jacobs Family Foundation, San Diego Gas & Electric/SEMPRA, Parker Foundation, Dr. Seuss Foundation, and the San Diego Commission on Children and Families/First 5. In 2002, the program's annual budget was $379,422.

Homeys Youth Foundation: Key Features (as of 2002)

- State office for HIPPY in California
- Health component currently being added
- New partnership with Even Start beginning
- Staff turnover is less than 5% per year
- 180 families
- $380,000 annual budget

Families Served

Since its inception, the program has served over 800 families. Currently (in 2002), 180 families receive HIPPY services at any one time. Any families with children ages 3, 4, or 5 are eligible for services. Families are recruited by home visitors at local schools, and community fairs using fliers. There is a waiting list of more than 100 families interested in enrolling in the program. Most of the families

served are Latino, although other families are African-American and, increasingly, Somalian.

Staffing and Caseloads
The 14 home visitors in the program generally have backgrounds in community development. Some have been with the program since its inception, and the current Program Coordinator started as a parent in the program. Staff turnover rate is very low, about 5% per year. Most staff are from the community and either have or have had a child in the program. Each home visitor serves 12-15 families.

Services
Home visitors seek to deliver four visits per month to families. The executive director reports that visitors are typically able to complete about 89% of those visits, and that 85% of children who enrolled in the San Diego HIPPY program as 4-year-olds in 1999 "graduated" in 2001.

In addition to traditional home visits, parent group meetings are offered on a monthly basis. Nine of the home visitors speak Spanish, and three speak Somalian. Materials are routinely offered in English and Spanish. Participating families welcome HIPPY, and see it as an educational program: children often refer to the home visitors as "teacher" and call their activities "homework."

The San Diego HIPPY program is adding new components and linking with other services. For example, in 2001, the San Diego HIPPY program began a health component. Home visitors now assess the health of the child, in addition to offering the regular HIPPY services and curriculum. Monthly group meetings have been expanded to include health information on topics such as nutrition, diabetes, cancer, and immunizations. This project has been funded by the Jacobs Family Foundation, the Hilbloom Foundation, and the San Diego Commission on Families and Children/First 5. Results of the initial round of health assessments will be available in April 2002, but preliminary results suggest some useful baseline information. For example, 99% of the children were rated as "healthy" or "very healthy" by their parents, and 99% reported that the children were up-to-date with their immunizations. Most could identify a private physician or community clinic where they received medical care, or a private dentist or community clinic where they received dental care. About half of the sample, however, reported some difficulties in seeking medical or dental care, primarily associated with transportation, language barriers, and cultural differences. Nearly 70% reported that their children regularly engage in some form of reading activity. About 12% of respondents reported that someone in the children's home smokes. Other information gathered about parents' preferences for additional services will be useful for program planning.

The San Diego HIPPY program has also entered into a partnership with a local Even Start site. Even Start is a federally-funded, two-generation family literacy program that enrolls families with children as early as at birth. With this partnership, Even Start services help parents learn to read, get their GEDs, and move into the workforce, while HIPPY services focus on school readiness and the parent-child relationship. Children also

receive center-based early childhood education to complement the home-based services offered through HIPPY. It is through this part of the San Diego HIPPY program that many Somalian immigrants are served. A total of 45 families per year will be served through this partnership.

Evaluation and Quality Assurance

The research firm WestEd conducted an evaluation of three HIPPY sites in California (San Diego, Long Beach, and San Francisco). Home visitors interviewed a total of 62 parents whose kindergarten children had participated in HIPPY the previous year, and WestEd staff interviewed the kindergarten teachers of 37 of these children. Parents reported that they read to their children at least three times each week (87%); they encouraged their children to write, draw, or paint (76%) or read signs or labels (68%) every day or almost every day; and they took their children to the library at least once a month (64%). Parents also reported high rates of involvement in their children's school activities, and 60% had volunteered to help in their child's classroom. Teachers rated 78% of the HIPPY children as average or above average in many areas related to verbal skills, and fully 80% were judged as moderate to excellent in learning skills such as curiosity, initiative, and self-direction in learning.

Challenges and Next Steps

The constant challenge for programs like HIPPY is securing continued funding. The San Diego HIPPY program has established solid relationships over the years with public and private funders and can depend on some firm funding. The new health component could allow for additional funding sources and offer the opportunity to leverage HIPPY expenses.

Programmatically, the San Diego HIPPY program seeks to partner with additional agencies and services. For example, the director of the National City PAT program and the State HIPPY Director have discussed opportunities to work together. (For a description of the National City PAT program, see Appendix C-5.)

For national information about HIPPY, contact:

Ms. Elisabet Eklind
Executive Director
HIPPY USA
220 East 23rd Street, Suite 300
New York, New York 10010
212-532-7730
info@hippyusa.org

For California information, contact:

Mr. Clinton Pearson
California HIPPY State Director
Homeys Youth Foundation/HIPPY
P.O. Box 131284
San Diego, CA 92105-1284
Phone: 619-264-1554

cp_grassroots@email.msn.com
URL: www.cahippy.com

HIPPY – California Sites

Site Location & Initial Training Date	Contact Person	Phone Number	Email Address
Santee (Educational Programs; 2000	Hope Baker	619-258-2255	hbaker@santee.k12.ca.us
San Francisco Unified School District (BELA); 1998	Lucia Perez Barrow	415-355-7330	ibarrow@muse.sfusd.edu
Los Angeles Unified School District (District H); 2000	Janie Chavers	323-266-7362	jchavers@mailcity.com
Long Beach Unified School District (Lee Elementary School); 1993	Betty Crain	562-494-5101	
Santa Barbara (Child Development); 2001	Ana Maya	805-963-4331 x249	amaya@sbsdk12.org
Downey (Migrant Education); 2000	Guadalupe Mendoza	562-922-6832	Mendoza_Lupe@lacoe.edu
San Diego (Homeys Youth Fnd – State Office); 1994	Clinton Pearson* Lisa M. Perry	619-264-1554 619-264-1554	Cp_grassroots@msn.com HIPPYORG@aol.com
San Diego (Homeys Youth Fnd—San Diego Unified); 1994	Danielle Pearson	619-264-9096	DanielleYvonne@msn.com
Stanislaus County (ISS); 2001	Charlyn Piper	209-525-5091	Cpiper@scoe.stanco.k12.ca.us
Diamond Bar (Pomona Unified Adult Education); 2001	Diana Sandoval	909-560-5059	
Pleasant Hill, Contra Costa County (Community Challenge); 1999	Nicole Porter	925-942-3300	nporter@cccoe.k12.ca.us

*Mr. Pearson is the State Director for the HIPPY program.

Appendix C-4
Nurse-Family Partnership (NFP)

The National View

Established in 1977 as a research-demonstration project in Elmira, New York, the Nurse-Family Partnership (formerly the Nurse Home Visitation Program) consists of nurses who visit first-time, low-income mothers and their families in their homes during pregnancy and the first two years of the child's life to accomplish three goals:

1. Improve pregnancy outcomes by helping women to alter their health-related behaviors, including reducing the use of cigarettes, alcohol, and illegal drugs;

2. Improve child health and development by helping parents provide more responsible and competent care for their children; and

3. Improve families' economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work.

The program has been tested in scientifically controlled studies in three communities (Elmira, New York; Memphis, Tennessee; and Denver, Colorado). As of 2002, the program operated in 250 communities in 22 states, serving more than 24,000 women. The largest concentrations of sites are in Colorado, Pennsylvania, Oklahoma, and California. In 2002, 10 programs operated in California, serving more than 2,500 women. Plans exist to expand services gradually to reach, by 2020, fifty percent of the low-income, first-time mothers in the country. New sites must commit to implementing the program model as it was tested in the earlier studies. The program developers believe that this is the best way to ensure that local programs will achieve the results produced in the studies.

Not surprisingly, therefore, program services have remained remarkably consistent across all sites. Briefly, nurses visit families from pregnancy (typically beginning before the end of the second trimester) through the child's second year of life. The frequency of home visits changes with the stages of pregnancy and as the child grows, and can be adapted to the mother's needs. The goal is to visit every week to two weeks, depending upon the phase of the program.

Nurse-Family Partnership:
Key Features (as of 2002)

- 250 communities; 10 in California
- Based on randomized trials in 3 communities (Elmira, NY; Memphis, TN; Denver, CO)
- Only one of the six major programs that requires nurse home visitors and prenatal enrollment of families
- Focus on economic self-sufficiency, as well as pregnancy outcomes and child health and development
- Continuous quality improvement system in which sites compare their performance against service levels at the Denver site

Each visit lasts approximately 60 to 90 minutes and is designed to encourage the mother to develop necessary knowledge and skills, and to change those behaviors that may lead to poor pregnancy outcomes, problems in child health or development, or compromised parental life course. Visitors help mothers strengthen relationships with family members and friends and link them with other health and human

services. Detailed visit-by-visit program guidelines are organized around challenges mothers and children typically encounter during pregnancy and infancy. Topics focus on six domains: (1) personal health; (2) environmental health; (3) life-course development; (4) maternal role; (5) family and friends; and (6) health and human services. Maternal, child, and family functioning are assessed, and specific strength-based interventions are used depending upon the results of those assessments and the interests and priorities of each family.

A key element in the model is the use of nurses as home visitors. In the communities where the program is now being implemented, the nurses work for departments of health, visiting nurse associations, or hospitals that provides primary care for mothers and children. Typically public health nurses, the visitors are required to have a minimum of a bachelor's degree. Each attends a two-week training course spread out over the first year of his or her involvement in the program. Each carries a caseload of 20 to 25 families and receives regular clinical supervision from a more senior nurse. In addition to receipt of training in the program model, nurses are expected to become proficient in assessing parent-infant interaction within the first year after the initial training. This requires 45 hours of continuing education provided by the University of Washington's Nursing Child Assessment Satellite Training (NCAST) and qualifies for three college credits. Continuing education after that is expected at each site but is tailored to the individual needs of each nurse. Areas of expected proficiency are made available as part of the training in the program model.

A hallmark of this program is its use of research to determine program effectiveness and to improve services. Research continues in several contexts:

- A longitudinal follow-up of families is being conducted in Elmira, Memphis, and Denver;

- An integrative economic analysis of the program's impact on government spending is under way using data from the randomized trials;

- Program implementation is monitored carefully in each site, using a management information system that is integral to the program.

Program services are usually funded through a variety of public and private sources. Public dollars include state and local dollars, as well as federal dollars from Medicaid, Maternal and Child Health Services Block Grant, and Temporary Assistance to Needy Families. The average annual program cost is $3,000 per family, with variations in cost primarily dependent upon local nurses' salaries.

The national office for the program, the National Center for Children, Families, and Communities at the University of Colorado, provides planning assistance to states, communities and operating agencies, nurse-training, evaluation services, and ongoing consultation in the development of the program.

The California View: The Fresno County Nurse Family Partnership

The Nurse-Family Partnership operates in ten California sites, with an 11th in Tulare County slated to begin operation in 2002.

Fresno County began its Nurse-Family Partnership in 1997, one of the first sites in the state. The target population of the Fresno program is first-time mothers who reside in the county. Fresno has an extensive outreach program that receives referrals from the Department of Employment and Temporary Assistance, doctors' offices, school nurses, and door-to-door outreach in high-risk areas. All first-time mothers at less than 28-weeks gestation are referred to the NFP Program. Women who are pregnant but do not meet the NFP eligibility criteria are referred to other home visiting programs in the county such as Black Infant Health, Babies First (Healthy Start), Comprehensive Case Management Program for high-risk women, Public Health Nursing, Cal-LEARN, or the Adolescent Family Life Program.

Families Served

Since its inception, the program has served 525 families; its average caseload at any one time is between 200 – 250 families. Families are primarily English- and Spanish-speaking, and most are low-income and MediCal-eligible. Hispanic, non-Hispanic white, African-American, Asian (Laotian, Hmong, and Cambodian), and Native American families all participate.

Each of the program's 14 home visitors serves between 20 and 25 families, depending upon the nurse's experience and whether or not she is full-time. The program had a $1,781,078 budget in 2001 (including local funding, with federal matching Medicaid dollars).

Services

While it is important to follow the planned schedule of visits, adjustments are made based on the family's own situation. The visits last about 1 to 1 ½ hours. The nurse's responsibilities during the visit are to listen to the client's needs and concerns, provide information and resources, and assist the client in setting and meeting health and life goals. The client's responsibilities are to be open to information, apply what makes sense, set her own goals, and carry out plans to meet those goals.

NFP in Fresno: Key Features (as of 2002)

- Basic program model adapted to add a mental health component and Mommy and Me playgroups. Mental health staff are shared with other agency programs
- Refers mothers not eligible for the NFP to other home visiting programs
- Serves Hispanic, non-Hispanic white, African-American, Asian, and Native American families
- 200-250 families
- $1.78 million annual budget

Fresno has added two components to the basic NFP program:

- A mental health component: a licensed supervising mental health clinician, a licensed mental health clinician, and two unlicensed mental health clinicians work with the nurses to assist the clients if they have any mental health issues. The clinicians also make home visits if the client agrees. The time of the clinicians is

shared with other home visiting programs, also administered by the Fresno County Department of Community Health, such as the Black Infant Health program, Babies First, and the Comprehensive Case Management Program for high risk women;

- A support group: the "Mommy and Me Play Group" aims to prevent the depression and isolation experienced by many first-time mothers. The group encourages mothers to implement the skills gained from the parent education training that they receive from nurses during their home visits. The support group also addresses topics such as parenting issues and English as-a-second-language, and organizes educational outings for mothers to increase their knowledge of local resources. First-time mothers in the program support each other as they become more empowered through solving parenting problems, breastfeeding, nutrition, and violence issues.

Evaluation and Quality Assurance

A well-tested and maintained record-keeping and clinical information system has proven to be both clinically and administratively useful in the successful operation of the program. Specific information is collected at each home visit and reported via data forms to monitor performance. These data forms, which cover maternal/infant health assessments, health habits, demographics, parenting issues, and personal beliefs, help the developers of the program at the National Center in Colorado provide useful feedback and technical assistance as implementation proceeds. Furthermore, the record keeping system helps to assure that families are receiving comprehensive assessments and education services by the nurse home visitors as well as referrals to services available in their community.

With the data from each site, the National Center then provides feedback that compares the performance of an individual site to the most recent randomized trial of the program in Denver, Colorado, and/or that calculates changes in outcomes over time. For example, participants in Fresno received an average of nine completed visits during pregnancy (three more than the participants in Denver), and an average of 14 completed visits during infancy (one more than participants in Denver). There was a 2% reduction in the number of women who reported smoking, and an average reduction of two cigarettes per day among women who continued to smoke.

Challenges

The largest challenge facing the program, according to Carol Henry, its nurse supervisor, is the difficulty in locating and hiring nurse home visitors. Competing with other employers in the community has sometimes been difficult, but the problem may be easing somewhat with slightly higher salaries now possible.

For information about NFP nationally, contact:

Matt Burh-Vogl, Senior Site Developer
University of Colorado Health Sciences Center
School of Nursing
4200 E. Ninth Avenue, C288-13
Denver, Colorado 80262
(303) 315-1573 or toll-free at 1-866-864-5226

For information about the NFP site in Fresno, contact:

Carol R. Henry, RN, BSN
Supervising Public Health Nurse
Maternal, Child & Adolescent Health
Human Services System
Department of Community Health
Chenry@fresno.ca.gov
(559) 445-3542

Nurse-Family Partnership – California Sites

Site Location & Initial Training Date	Contact Person	Phone Number	Email Address
Fresno County, Dept. of Health Jan. 1998	Connie Woodman Carol Henry (S) Gail Williams (S)	559-445-3307 559-445-3542 559-445-3542	cwoodman@fresno.ca.gov cturk@fresno.ca.gov gwilliams@fresno.ca.gov
Kern County, Dept. of Public Health (Bakersfield) Jan. 2001	Cindy Wasson Bobbi Harms	661-868-0400 661-393-3159	wassonc@co.kern.ca.us harmsb@co.kern.ca.us
Los Angeles County, Dept. of Health Services Jan. 1998	Jeanne Smart Cindy Chow (S)	213-240-8192 213-240-8425	jsmart@dhs.co.la.ca.us cchow@dhs.co.la.ca.us
Monterey County, Dept. of Health Jan. 1999	Linda Wolleson (S)	831-755-4611	wollesenl@co.monterey.ca.us
Orange County, Dept. of Health Jan. 1999	Kathleen Parris Pat Place (S)	714-834-8150 714-834-8218	kparris@hca.co.orange.ca.us pplace@hca.co.orange.ca.us
Riverside County, Health Services Agency Oct. 2000	Judy Halstead Earp Angie Camacho (S)	909-358-5516 909-358-5516	jearp@co.riverside.ca.us acamacho@co.riverside.ca.us
Sacramento County, Dept. of health and Human Services Mar.2001	Bernice Walton Amelia Baker Jane Wagener (S)	916-875-5471 916-875-2062	waltonb@dhhs.co.sacramento.ca.us bakeram@saccounty.net
San Diego County, Dept. of Health Oct. 1999	Rose Fox Gaby Kuperman (S)	619-409-3303 619-668-3641	rfoxxxhe@co.san-diego.ca.us gkuperhe@co.san-diego.ca.us

Santa Clara Valley Health & Hospital Systems, Public Health Dept. Jan. 1999	Sandie Couser Laura Brunetto (S)	408-299-4305 408-299-4305	sandie.couser@hhs.co.santa-clara.ca.us laura.brunetto@hhs.co.santa-clara.ca.us
San Luis Obispo County, Public Health Dept. July 2001	Irene Vega Julia Pierce (S)	805-781-5535 805-788-2061	ivega@co.slo.ca.us jpierce@co.slo.ca.us
Tulare County Health and Human Services April 2002	Mary Ontiveros Jeannette Altair (S)	559-737-4660 x 2303	montiver@tularehhsa.org

(S) denotes the nurse supervisor for the program

Appendix C-5
Parents as Teachers

The National View

The Parents as Teachers (PAT) program began as a pilot project in 1981, implemented by the Missouri Department of Elementary and Secondary Education in collaboration with four school districts. Concerned that school-district programs for disadvantaged preschoolers that began at age three were intervening too late, school-district program designers sought to test the feasibility of influencing children's education from the onset of learning through a partnership with their parents. The goal of the intervention was to reduce the number of children entering school in need of special help.

The results of an independent evaluation of the program's benefits to participating children, as assessed at their third birthdays, led to funding for statewide implementation. The findings of this and subsequent studies contributed to the program's expansion to 2,879 sites in all 50 states, the District of Columbia, and six other countries. PAT now serves some 500,000 children prenatally to age five. A total of 88 PAT programs operated in California in 2002. (By 2003, the total was 109 PAT programs in California.)

The PAT program is based on two simple truths: babies are born learners, and parents play a critical role from the beginning in determining what their children will become. The tenet that *all* parents deserve to be supported in their role as first teachers led to a program designed for the voluntary participation of all families, and adaptable to the needs of broadly diverse families, cultures, and special populations. The program's major goals are to (1) empower parents to give their children the best possible start in life through increased knowledge of child development and appropriate ways to foster growth and learning; (2) give children a solid foundation for school success; (3) prevent and reduce child abuse; (4) increase parents' feelings of competence and confidence; and (5) develop true home-school-community partnerships on behalf of children.

Parents as Teachers: Key Features

- 2,879 sites; 88 in California in 2002 (109 by January, 2003)
- All California Even Start programs will be using PAT
- Home visits and parent group meetings
- Focus on parent-child relationship and child development. Economic self-sufficiency issues usually referred to other agencies
- Specialized curricula available for teen parents and child care providers
- Curriculum includes videotapes and incorporates latest brain development research

PAT program services include four components:

1. Regularly scheduled personal visits by trained and credentialed parent educators who provide information on the child's development, model and involve parents in age-appropriate activities with the child, and respond to parents' questions and concerns.

2. Group meetings in which parents share insights and build informal support networks.

3. Health and developmental screening to detect and treat any emerging problems as early as possible.

4. Linking of families with needed community services that are beyond the scope of the program.

Home visits are usually one hour in length and are scheduled monthly, biweekly, or weekly, depending upon family needs and local program budgetary restrictions. In Missouri, for example, state funds provide for 25 visits per year for high-need families—that is, families with one or more of the following characteristics: teen parents, single parents, children of parents with disabilities, low educational attainment, English as a Second Language, unemployment, chemical dependencies, foster parents, numerous family relocations, high stress, or involvement with the corrections system, or mental health, health, of social service agencies.

PAT programs are offered by school districts, hospitals, churches, and social service agencies as stand-alone programs or as part of more comprehensive service-delivery systems, such as Head Start or Even Start programs, or family resource centers. As many as 92 programs operate in conjunction with family resource centers, for example, including 32 in Connecticut and 1 in California. Funding is often a combination of federal (for example, Title I, Goals 2000, Even Start, and Head Start), state, and local dollars, as well as private monies.

Established in 1987, the Parents as Teachers National Center (PATNC) develops, promotes, and evaluates programs and public policies that provide family support and education through the earliest years of a child's life. PATNC provides training and technical assistance, curriculum and materials development, and research and evaluation coordination in support of quality PAT programs. PATNC maintains updated implementation plans for all programs, and programs submit annual reports about the services delivered and populations served.

Although programs select the personnel who will serve as parent educators, PATNC strongly recommends professional education and experience in the fields of education, health care, or social work related to young children and families. All parent educators (home visitors) receive one week of preservice training by trainers certified by PATNC. PATNC credentials parent educators on annually, contingent upon the local administering agency's approval of their service to families and their completion of the required 10 to 20 hours of annual in-service training, depending on length of service. Responsibility for supervision of service personnel rests with the local administering agency.

The PAT curriculum has evolved over the years. Originally designed as a birth- or prenatal-to-age-three program, the PAT curriculum now extends through age five. Special curricula have been created for child care providers and for teen parents More than 1,120 programs now operate to age 5. In 76 programs, child care providers are trained to deliver home visits as well.

The entire curriculum was recently revised to translate the latest research about brain development into improved outcomes for young children. Dubbed the Born to Learn™

Curriculum and launched in 1999, the curriculum combines detailed home visiting plans in weekly, biweekly, and monthly formats with resource materials for parent educators, handouts for parents written at two different reading levels, and a 16-segment video series.

The California View: The National City PAT Program

Currently, 88 PAT programs operate in California, and at least 30 more are slated to begin operation within the next year, as Even Start programs throughout the state adopt the PAT curriculum for the home visiting portion of their services to families.

Established in 1987, the National City School District site was the first PAT program in California, and now serves as the center for training for PAT programs in the state. Training sessions in different cites are conducted almost every month throughout California.

Located about eight miles north of the US-Mexico border, the National City program has been supported over the years by funds from Title I, Title VI, First 5, private foundations, and income from providing PAT training. The program's current annual home visiting budget is $87,500.

Families Served

Since its inception, the PAT home visiting program has served over 2000 families. Currently, the maximum capacity is about 100 families at any one time. Any families with children between the ages of birth and four years of age are eligible for services. If families enroll prenatally, they are offered home visits every other month; if they enroll after the birth of their child, they are offered monthly home visits. Most families enroll within the first year of their children's lives.

The National City PAT Program: Key Features (as of 2002)

- Training center for all PAT home visitors in California
- Operates out of a school district, and in conjunction with a community-based family resource center
- In early stages of new effort to deliver home visiting services to license-exempt child care providers
- Cross-referral partnership with local ABC program
- 2001 recipient of First 5 school readiness grant
- 77 families
- $87,500 annual budget for home visiting

Families are recruited via presentations at the schools, community events, and a flyer sent home to parents at the school twice each year (connections facilitated by school district sponsorship of the PAT program). There is usually a waiting list of families interested in enrolling in the program. About 99% of the families served through the program are Hispanic.

Staffing and Caseloads

The six home visitors in the program generally have backgrounds in child development, and bring some experience in working with families. All speak Spanish. Three home visitors were actually parents served through PAT before they became home visitors. Some of the home visitors have been with the program since 1989, and only two home visitors have left the program since its

inception. Each home visitor serves 20-25 families.

Services and Linkages
Home visitors seek to deliver monthly home visits. Parent group meetings are offered each month on topics including brain development, child behavior, nutrition, health, and community resources. Materials are routinely offered in English and Spanish. Program staff estimate that perhaps 60% of families stay in the program for three years.

The school district has sponsored PAT over the years because it believes that the program helps to prepare children for school, increases parent involvement in their children's education and parents' partnerships with the community and the schools. In 1994, the program entered into the National City Collaborative, which is a partnership of 52 member organizations. PAT services are now out-stationed, along with services of seven other agencies, at school-based family resource centers. The co-location of services permits one-stop shopping for families, who can easily access a range of services, including health insurance coverage, health care services, TB testing, mental health counseling, consumer credit counseling, information on housing, job skills training, English as a Second Language classes, personal growth and self-esteem classes, women's support groups, and parenting classes. Child care is provided while mothers are in class. Additional service linkages are available to community-based after-school youth programs.

When children turn 3 years of age, they "graduate" from PAT, and graduation ceremonies are held on the school campus. Children are then transitioned to the on-campus preschool and child development centers.

The program has received First 5 funding to serve license-exempt child care providers. Using a curriculum developed by the PAT National Center, home visitors work with the license-exempt child care providers (typically kith and kin providers) to support them in their role as child care providers, and to provide them with information on topics such as Everyday Math, Safety, Amazing Brain, Environment, Emerging Writing, and Blocks.

In addition, the National City program has developed a health resource binder, with funding from the Alliance Healthcare Foundation, that provides age-appropriate health information on topics including development, nutrition, safety, behavior, dental health, and resources. The program also offers the binder to all home visitors who are trained by the National City site.

The National City PAT program has also worked in partnership with a local ABC program. When families needed services beyond child development and school readiness, the PAT program referred them to the local ABC program, which offered a more intensive visiting schedule and focused on serving families at risk for child abuse and neglect. When ABC families reached their program goals and their most critical needs were addressed, then they could be referred to the PAT program for additional services.

Evaluation and Quality Improvement
Beginning in 1991, SRI International evaluated the effects of the National City program by comparing children who completed three years of services with three-year-olds from the community who had never received PAT services. Results indicated benefits for the PAT "graduates" in child development, and in parents' knowledge about child development, attitudes toward parenting, parenting behaviors, and the home environment.

Challenges and Successes
Program staff note that, beyond the benefits the program brings to the children, many of the parents who participate in the program have moved on to volunteer in the program, to attend ESL classes, and, in some cases, to attend college. A key challenge is the ability to hire a more culturally diverse staff.

For additional information, contact:

Parents as Teachers National Center, Inc.
ATTN: Public Information Specialist
2228 Ball Dr.
St. Louis, Missouri 63146
Phone: (314) 432-4330
e-mail: info@patnc.org

Parents as Teachers – California Sites

City	Program Name	Program Sponsor	Contact Person	Phone Numbe	E-mail Address
Alameda	Even Start Family Literacy Program	Alameda Unified Schools	Cynthia Wasko	510-769-7205	alamedaevenstart@home.com
Alturas	Modoc County Even Start	T.E.A.C.H. And Modoc County of Education	Jennifer Rayas	530-233-7155	even@hdo.net
Anaheim	CBET	Anaheim City School District	Luz Gonzalez	714-517-7527 x 4113	lgonzalez@acsd.ca.k12.us
Anaheim	Even Start	Anaheim City School District	Diana Serrano	714-517-7575	dserrano@acsd.ca.k12.us
Anaheim	School Readiness	Anaheim City School District	Elaine Coggins or Cara Najera	714-517-7575	cnajera@acsd.ca.k12.us
Apple Valley	State Preschool PAT	San Bernardino County Superintendent of Schools	Hana Nute	760-242-6322	
Arroyo Grande	LMUSD Even Start/Parents as Teachers Program	Lucia Mar Unified School District Adult Education	Sandy Quintiliani	805-473-4244	
Bakersfield	Cal-Works/Family Literacy Program	Bakersfield City Schools	Jan Hensley	661-631-4881	

Berkeley	Berkeley Even Start Program	Alameda County Office of Education	Lauretta Beckett	510-670-4542	laurettab@acoe.k12.ca.us
Bishop	Tu-nee-wa Novee Even Start Program	Owens Valley Career Development Center	Dolly Manuelito	760-872-2115	dollymanuelito@hotmail.com
Bloomington	Parents As Teachers / Special Projects	Colton Joint Unified School District	Diane Mumper	909-876-4250	
Buena Park	Buena Park Even Start	Buena Park School District	Christie Baird	714-670-6432	
Campbell	Family Learning Center - Parents as Teachers	Campbell Union School District	Gina Phi	408-341-7000 4182	Gina_Phi@campbellusd.k12.ca.us
Caruthers	Even Start - Parents as Teachers	Caruthers Unified School District	Beth Coulourianos	559-864-3262	bcoulourianos@caruthers.k12.ca.us
Castroville	Even Start Family Literacy Program	North Monterey County United School District	Richard Diaz	831-632-0877	crubvalca@monterey.k12.ca.us
Chico	Chapman Even Start PAT	Chico Unified School District	Sheri L. Zeno	530-891-3181	szeno@chicousd.org
Chico	Parents as Teachers	Four Winds of Indian Education, Inc.	Betty Jo Smith	530-895-4212	beejsmth@yahoo.com
Chula Vista	Chula Vista Even Start Family Literacy Program	Chula Vista Elementary School District & City of Chula Vista	Carolyn Scholl	619-425-9600	1515cscholl@cvesd.k12.ca.us
Clovis	Clovis Even Start, SMART Start PAT	Clovis Unified School District	Vivian Simons	559-327-2818	viviansimons@cusd.com
Corona	Project Even Start - Parents as Teachers	Corona-Norco Unitied School District	Renee K. Sanabria	909-736-3375	hgesl@nescape.net.
Covina	Covina Valley Even Start Family Literacy Program	Covina Valley Unified Schl Dst	Wanda L. Pyle	626-974-7000 x 2072	wpyle@cvusd.k12.ca.us
Eureka	Eureka Even Start - Parents as Teachers	Eureka City Schools	Carol Harvey	707-441-3329	harveyc@eurekacityschools.org
Fallbrook	Parents as Teachers	Fallbrook Union Elementary School District	Kathy Gausepohl	760-723-6727	kgausepohl@fuesd.k12.ca
Fontana	Parents as Teachers Program	Fontana Unified School District - Child Development	Patty Lynch	909-357-5000	lyncpa@fusd.net
Fresno	Burroughs Even Start Family Literacy Program	Fresno Unified School District	Xee Yang	559-255-6610	xdy27@hotmail.com
Fullerton	Fullerton Even Start	Fullerton School District	Nancy Kozma	714-447-7499	nancy_kozma@fsd.k12.ca.us

Geyserville	Geyserville Unified School District Even Start Program	Geyserville Unified School District	Terry Murray	707-857-3410	msmrri@yahoo.com
Gilroy	Even Start Family Literacy Program	Parents as Teachers MACSA/Even Start	Rudy Barraza	408-842-4863	
Glendale	Even Start Family Literacy Program	GUSD Even Start	Jo Ann Daly	818-241-3111 x 508	
Glendale	Even Start Program - Parents as Teachers	New Horizons Family Center	Rocio Bach	818-545-9848	nhpo@earthlink.net
Half Moon Bay	Coastside Even Start	Cabrillo Unified School District	Roxana Fine	650-712-7182	finer@cabrillo.k12.ca.us
Hawthorne	Hawthorne Even Start Family Literacy Program	Hawthorne School District	Donielle Knowles	310-679-7984	dknowles@hawthorne.k12.ca.us
Healdsburg	Even Start PAT	Healdsburg/Cloverdale Unified School District	Divina Hernandez-Giron	707-431-3470	dhernandez@husd.com
Hoopa	Hoopa Even Start Family Literacy Program	Hoopa Tribal Education Association	Pamela Hammond	530-625-1992	hupahro@hotmail.com
Huntington Beach	Even Start Family Literacy Program	Ocean View School District	Joyce Horowitz	714-843-6938	jhorowitz@ovsd.org
La Habra	La Habra Even Start Family Literacy	La Habra City School District	Marion Dunkerley	714-526-4729	mcadunkerley@aol.com
La Mesa	Family Literacy Program	Lemon Grove School District	Margaret M. Ikezaki	619-825-5722	mikezak@lgsd.k12.ca.us
Lancaster	Prop. 10 Home Based Program	The Children's Center of the Antelope Valley	Cathy Overdorf	661-949-1206 x 219	
Lemon Grove	Lemon Grove School Readiness Project	Lemon Grove Project	Shonna Irving	619-433-3410	sirving@lgsd.k12.ca.us
Lompoc	Parents As Teachers Lompoc USD	Lompoc Unified School District	Cheryl Sampson	805-737-0429	mistcs@excite.com
Lone Pine	W.F.G. Even Start Family Literacy Program	Lone Pine Unified School District	Joanne Parsons	760-876-4721	
Los Angeles	99th Street Elementary School - Even Start Program	Los Angeles Unified School District	Janna Woods	323-249-0319	
Mammoth Lakes	Mono County 1st Five Home Visiting Program	Mono County Health Department	Lynda Salcido	760-924-1842	lyjt@aol.com
Modesto	Modesto Even Start	Modesto City Schools	Ruthann Kunishige	209-576-4653	kunishige.r@monet.k12.ca.us

Mountain View	Mountain View-Los Altos Adult Education Even Start Program	Mountain View-Los Altos Union High School	Jeannie Richter	650-940-6039	jeannierichter@yahoo.com
Murrieta	MVUSD Parent Center	Murrieta Valley Unified School District Parent Center	Thaya Kroencke-Fineout	909-304-1623	sofineout@msn.com
Napa	Napa Valley Language Academy Even Start	Napa Valley Unified School District	Cynthia Meza	707-253-3930	cmeza@nvusd.k12.ca.us
National City	Parents as Teachers-National City	National City Co Laborativo	Lydia Rodriquez	619-336-8374	lydiar@nationalk12.ca.us
Newhall	Newhall Even Start	Newhall School District	Laura Sanders	661-259-8480	lsanders@newhall.k12.ca.us
Nuevo	Even Start Family Literacy Project	Nuview Union School District	Jan Stockton-Miller	909-928-0066	jstockton-miller@nuview.k12.ca.us
Nuevo	Nuview Parents as Teachers Program	Nuview Union School District	Jan Stockton-Miller	909-928-3392	jstockton-miller@nuview.k12.ca.us
Oakland	City of Oakland, Even Start Program, San Antonio	Department of Human Services	Tracey Black	510-637-0391	tmblack@oaklandnet.com
Oakland	Even Start Family Literacy Project	YWCA of Oakland	Julia Fong Ma	510-451-2682	jfongma@ywcaoakland.org
Oakland	Even Start Family Literacy Program	Lao Family Community Development, Inc.	Nancy E. Yamamoto	510-535-9323	laofamilyevenstart@hotmail.com
Oakland	Fruitvale Even Start Family Literacy Program	The Spanish Speaking Unity Council	Olga Valencia	510-535-6946	ovalencia@unitycouncil.org
Orosi	CONNECTIONS	Cutler-Orosi Joint Unified School District	Debbie Przybylski	559-528-3635	dsprzyblski@cutler-orosi.k12.ca.us
Oxnard	Even Start Family Literacy Program	City Impact Even Start	Maria Guadalupe Lopez	805-271-8362	lopezlupe2@aol.com
Pacific Grove	Parents as Teachers	Pacific Grove Adult Education	Gail Root	831-646-6623	groot@pgusd.org
Pala Pala	Even Start/Project REZ FEATHER	Pala Band of Mission Indians	Doretta J. Musick	760-742-1997	dmusick@fuhsd.net
Palm Springs	Early Childhood Education Program	Palm Springs Unified School District	Patricia Dorado	760-416-8090	pdorado@psusd.k12.ca.us
Perris	Preschool Program	Perris Elementary School District - Preschool Program	Erika Tejeda	909-657-1441	erikatejeda@yahoo.com

Porterville	Project LIFT-Literacy Intergenerational Family Teaching	Alta Vista Elementary School District	Debbie Elium	559-782-5700 x 2033	
Poway	"Ready To Learn" Grant Project	Poway Unified School District	Kelly Riley	858-748-0010 x 2750	
Red Bluff	FAST/ Corning Even Start	Tehama County Department of Education	Ann Ratay	530-528-7390	aratay@tcde.tehama.k12.ca.us
Red Bluff	T-4-2/Red Bluff Even Start	Tehama County Department of Education	Gloria Lofthus	530-528-7389	glofthus@tcde.tehama.k12.ca.us
Redding	Even Start Family Literacy - P.A.T.	Enterprise School District	Barbara Grosch	530-224-4126	bgrosch@enterprise.k12.ca.us
Redding	Even Start PAT	Center for Quality Education	Phil Hopkins	530-227-7704	pmhopkins@adm.tech.net
Redwood City	Redwood City Even Start Project	Redwood City School District	Gloria Nudelman	650-569-2332	gloriana@flash.net
Redwood City	Redwood City Family Centers	Redwood City School District	Patricia Merles-Lopez	650-361-8730	pmerlesloopez@rcsd.k12.ca.us
Richmond	Even Start Family Literacy Program	Catholic Charities/WCC USD	Marta Garcia	510-234-5305	mgarcia@cceb.org
Riverside	Even Start Family Literacy Program/ PAT Program	Riverside Unified School District - Longfellow Elementary	Bertha Toner	909-788-7107	btoner@rusd.k12.ca.us
Riverside	Parents as Teachers	Riverside Unified School District	Leon Johnnie Tabor III	909-788-1162	
Rowland Heights	Even Start Parents as Teachers	Rowland Unified School District	Maylani Sexton	626-935-8421	lanisexton@juno.com
Salinas	Infant Program Parents as Teachers	Monterey County Office of Education	Shirley Stihler	831-755-1440	sstojer@monterey.k12.ca.us
Salinas	Natividad & Mountain Valley Family & Child Development PAT	Children's Service International	Roni O'Connell	831-424-693924 csi2@redshif.com	
Salinas	Project Alisal Even Start PAT	Alisal Union School District	Bertha A. Guzman de Jasso	831-753-5760	bjasso@monterey.k12.ca.us
Salinas	Salinas Adult School Parent Center	PAT Salinas Adult School/Salinas Union High School District	Carole Singley	831-753-4273	csingley@salinas.k12.ca.us
San Diego	Early Head Start PAT	Neighborhood House Association	Sarah Garrity	619-757-1050	ecao@neighborhood.org

San Diego	Giant Steps Bayside Community Center	Norma Klepper	858-278-0771	nklepper@baysidecc.org	
San Diego	Jumpin Jax Helping Hands Even Start PAT	San Diego Unified School District Child Development Programs	Richard Joniaux	858-496-1958	
San Diego	Parents as Teachers	McGill School of Success	Deborah Huggins	619-239-0632	
San Diego	Parents as Teachers	Home Start, Inc.	Kathryn Ingram	619-692-0727	www.homestart.org
San Diego	Parents as Teachers - East County	Catholic Charities Diocese of San Diego	Mehboob Ghulam	619-287-9454	mghulam@ccdsd.org
San Jacinto	Native American Parental Assistance Program NAPAP	Ahmium Education , Inc.	Dondi Silvas	909-654-2781	dondis@yahoo.com
San Jacinto	Pre School in a Box	California Family Life Center Foster Family Agency	Katherine S W Knight	909-654-2352	cflckids@msn.com
San Joaquin	Parents as Teachers	Golden Plains Unified School	David McDonald	559-693-1115	dmcdonald@gpusd.k12.ca.us
San Jose	Even Start Family Literacy Program	Mt. Pleasant Elementary School District	Rachel Bergine	408-347-3372	
San Juan Capistrano	Migrant Education/Capistrano Office	Migrant Ed. Reg. TX-San Diego	Maria Teresa Pierce	949-488-3438	
San Rafael	Alcanza - Even Start	Community Action	Marin Ray Capper	415-499-1595	alcanza@sbcglobal.net
San Rafael	Bahia Vista Even Start	Even Start (San Rafael)	Rebecca Stewart	415-485-2318	rstewart@marin.k12.ca.us
San Ysidro	Even Start Family Literacy Pgm - P.A.T.	San Ysidro School District Even District	Norma Mier	619-428-4476 x 3738	
Santa Ana	Even Start Project Future	Santa Ana Unified School District	Ana Lira	714-430-6100	alira@sausd.k12.ca.us
Santa Ana	Parents as Teachers	United Cerebral Palsy of Orange County	Ana Reyes	714-557-1291	
Santa Clara	Even Start Parents as Teachers	Santa Clara USD Adult Educational Options	Angela West Gibson	408-423-3514	
Santa Cruz	Parents as Teachers Program	Walnut Avenue Women's Center	Cathy Lusk	831-426-3062	wawc@cruzio.com

Santa Rosa	Even Start, Title VII, McKinney - P.A.T.	Santa Rosa City Schools	Janet Barrows	707-521-2510	jbarrows@srcs.k12.ca.us
Selma	FRC@ Roosevelt Elementary - P.A.T.	Selma Unified School District	Fran Perez	559-898-6700	fperez@selma.k12.ca.us
Shasta Lake City Fame/Even Start Program	Local Indians for Education, Inc.	Patti Renenger	530-275-1513	gprenenger@yahoo.com	
Skyforest	Rim Parents as Teachers	Rim Family Services	Elizabeth Dimond, MFT	909-336-1800	rimfamily@dreamlinks.net
Stockton	Great Beginnings	United Cerebral Palsy of San Joaquin County	Victoria Simpson	209-956-0290	vsimpson@ucpsj.org
Stockton	Success By 6 Parents as Teachers	United Way of San Joaquin County Success by 6	Corinne Cervantes	209-320-6216	ccervantes@unitedwaysjc.org
Temecula	Temecula Even Start Family Literacy Program	PAT Temecula Valley Unified School District	Marilyn Skrbin	909-506-7989	mskrbin@tvusd.k12.ca.us
Tulelake	Migrant Even Start	T.E.A.C.H., Inc.	Anna Porter	530-667-2035	
Tulelake	Tulelake/Newell Even Start	T.E.A.C.H., Inc.	Anna Porter	530-667-2147	
Union City	New Haven Even Start Program	New Haven Unified School District	Francisca Montes	510-489-2185 213	francisca-montes@nhusdk12.ca.us
Visalia	Visalia Unified Even Start	Visalia Unified School District/Visalia Adult School	Ligia Hemaidan	559-730-7655	lhemaidan@visalia.ca.us
Warner Springs	Even Start - State and Federal SCAIR, Inc.	Wanda Michaelis	888-217-2247 227	scaib@hotmail.com	
Weed	Siskiyou Even Start	Siskiyou Child Care Council	Dennis Ball	530-938-2748	
West Sacramento	Even Start/Family Literacy Program	Washington Unified School District	Hilda Tonarely	916-375-7630	

Source: www.patnc.org (as of 1/2003)

Appendix C-6
The Parent-Child Home Program (PCHP)

The National View

Established by the Verbal Interaction Project in 1965 under the direction of Dr. Phyllis Levenstein, the Parent-Child Home Program is an intensive home visiting model focused on increasing parent-child verbal interaction and enabling parents to prepare their children to enter school ready to learn and to achieve long-term academic success.

Currently, over 3,600 families are served at 132 program sites in 10 states. The largest concentration of PCHP sites are found in Massachusetts and Pennsylvania where the program receives earmarked state funds, in South Carolina, where training and start-up funds are provided through the SC Department of Education, and in New York, where sites receive state aid through the county Bureaus of Cooperative Education Services (BOCES). The State of Pennsylvania is supporting a 30-site expansion as part of a large, statewide school readiness initiative. The state has allocated $12 million over the next 3 years in set-aside Temporary Assistance for Needy Families (TANF) funds to support the establishment of 30 new sites across the state. Many of these sites will be operated by or conjunction with local family resource centers. In early 2002, three sites operated in California, with a fourth site due to begin services earlier in the year.

Families receive two home visits per week for a minimum of 23 weeks in each of two years (a total of at least 92 visits over the course of two years, which typically follow the school year calendar). Families with children as young as 16 months may enter the program, but participants are usually families with 2- and 3-year-olds.

Paid paraprofessionals from the community, many of whom are former parent-participants in the program, work with families that are challenged by poverty, low levels of education, language barriers, and other obstacles to educational success. These are often the first jobs for the paraprofessionals, and advancing their education and careers is an important additional impact of the program.

PCHP works with primary caregivers to develop their children's literacy and language skills and to prepare children to enter school ready to succeed. The PCHP curriculum focuses on two major areas: cognitive (sensory-motor skills, conceptual development, language development) and affective (social emotional competence and parenting skills). The home visitor emphasizes verbal interaction and learning through play using carefully chosen books and toys.

The Parent-Child Home Program: Key Features

- 132 sites; 3 in California
- Serves 2-3-year-olds
- Paraprofessional home visitors
- Focus on cognitive and affective development
- Delivers books and toys to families free of charge

Families receive a minimum of 12 books and 11 toys free of charge each year. Many families have no children's books and few developmentally appropriate toys when they enter the program, but, upon completion, each family has a library of children's

literature and a collection of the types of educational puzzles, blocks, and simple games that their children will be expected to have experienced when they enter kindergarten.

The program also seeks to connect families with needed services to help them reach the next appropriate educational step for their children and themselves. To that end, the Parent-Child Home Program Coordinator serves as a source of referrals to link families with social services or early childhood and parenting education opportunities in their communities.

The national office of the Parent-Child Home Program serves as a clearinghouse for the more than 35 years of evaluation and research on PCHP. The National Center provides start-up and technical assistance to individual sites; training and administrative materials to program coordinators, who then train their own home visitors locally; an annual conference for coordinators and home visitors; and assistance with conducting research and evaluation projects and with pilot projects serving special populations, such as homeless families, teen parents, and children younger than 16 months.

Parent-Child Home Program replications are sponsored by school districts, individual schools, social service agencies, community-based organizations, community health centers and public libraries. Fully 62 of PCHP's 132 sites are operated through school districts. An interesting example is the Brooklyn site, which opened in the fall of 2001. In Brooklyn, the home visitors are all school district employees who were already employed by the district to work in family resource centers in a number of the district's elementary schools. These paraprofessionals are now spending part of their week conducting Parent-Child Home Program home visits with families living in the area served by the elementary school where they work. The Parent-Child Home Program model enables these family workers to bridge the gap between home and school, reaching families who might not come in to school to use the family center or attend a meeting or a special event. The connection with the school their child will be attending (and where older siblings may already be enrolled) increases their comfort level and their future level of involvement with the school.

PCHP programs are funded through a variety of sources, including Title I; Even Start; TANF; state funds, including budget line items, First 5, and parenting and literacy funds; school district funds; and private foundations and corporations. The average annual cost is $2,000 per family, and the average program site budget is $120,000.

The California View: The Parent Child Home Program at the Eisner Pediatric & Medical Center in Los Angeles

The PCHP currently has three sites in operation in California and a fourth site which has just received funding and will be trained this spring. All four sites are funded with Proposition 10 grants.

The Los Angeles site has been in operation the longest, and represents an interesting variation because it is closely linked with a health clinic.

Established in 2000, the Los Angeles program, administered by the Eisner Pediatric & Medical Center (Center), currently serves 150 families. The program grew out of the Center's Early Intervention Program, an already-established home visiting program that provided infant stimulation to children under age three with special needs. When Proposition 10 dollars became available, program administrators decided to expand services to reach a broader group of children.

Families Served

Currently, about half of the families served are Latino and about half are African-American. Families come from diverse cultures: Mexican, Guatemalan, Salvadoran, Peruvian, Belizian, Panamanian, and African. Adult participants in the program range in age from 15 to 58, and include several grandmothers who are raising their grandchildren. Participating families are primarily of extremely low socioeconomic status; parents often have not completed high school, and are single parents. Home visitors speak the languages of the families they serve, and materials are available in English and Spanish.

Initial recruitment came primarily from referrals from pediatricians in the health clinic for Latino families, and from a broader range of sources, such as schools, churches, WIC, and even local laundromats, for African-American families. Currently, referral sources also include word-of-mouth, and the program has a waiting list.

Staffing and Caseloads

Ten home visitors, primarily paraprofessionals, visit the families. All had prior experience with children and families, including college-level education in child development or working as a teacher's assistant, and being a mother. All the home visitors were from the community they would visit, and were motivated to contribute to and make a change to that community. Two co-coordinators oversee the program and supervise the home visitors. They too are mothers, and they also have experience in child care, supervision, and administration of child-centered programs. Each home visitor carries a caseload of about 10 families, and the co-coordinators each supervise five home visitors.

The Eisner Pediatric & Medical Center PCHP Program: Key Features

- Linkage with a medical center makes access to health insurance and health and dental services easier
- Partnership with Reach Out and Read program
- Primarily paraprofessional home visitors
- 150 families
- $330,000 annual budget

Program Services and Linkages

Because of its connection with a health clinic, the program is able to link families with health services more easily than if it were a stand-alone program. Parent-Child Home Program Coordinator Julietta Cruz notes that in the first year, "Approximately 15% of our families were not medically insured. We immediately brought them into the clinic to assess which plan to apply for. Now all children in the program have some type of medical coverage and all are receiving medical and dental services." Through the connection with the health clinic, families are able to receive medical, dental, early

intervention, mental health, and speech and occupational therapy services. The clinic also offers parenting classes; health education classes about topics such as nutrition, asthma, diabetes, prenatal care, or car seat safety; and the Reach-Out and Read program, in which pediatricians "prescribe" books to families with young children.

Funding
The annual program budget (about $330,000) is funded primarily through county Proposition 10 dollars, with a small amount of matching funds provided by the Medical Center.

Successes and Challenges
The challenge has been to keep families consistent and committed to the program, but the program reports low drop-out rates, and good completion of home visits. Families eventually receive all the program's content, because, if a visit is missed, the content is reviewed at the next visit. The program coordinator reports that, so far, fewer than 5% of families have ended enrollment. Co-coordinators contact families each month either through visits, phone calls, or a newsletter, and home visitors strive for two visits each week.

Families are encouraged to understand the importance of their child's early childhood education, and the importance of their own roles as their child's first teacher. Because of this program, over half the parents have returned to high school, sought employment to improve living conditions, enrolled in and completed ESL courses, and developed an interest in the future of their children.

Four of the 10 home visitors have been with the program since its inception. Home Visitors are encouraged to commit to the program for at least one year; only one visitor left the program in 2001. Professional development for the home visitors is emphasized, and some of the home visitors are currently enrolled in college, striving to learn more about child development. Both Co-coordinators have returned to college to finish their degrees in child development and sociology.

For additional information about the Parent-Child Home Program, contact:

Sarah E. Walzer
The Parent-Child Home Program
800 Port Washington Blvd.
Port Washington, NY 11050
516-883-7480 (telephone)
516-883-7481 (fax)
www.parent-child.org
Swalzer@parent-child.org

For information about the Los Angeles program, please contact:

Julietta Perez-Cruz
(213) 746-1037 x 3325
jcruz@pedcenter.org

The Parent-Child Home Program – California Sites

Site Location & Initial Training Date	Contact Person	Phone Number	Email Address
Los Angeles (Eisner Pediatric and Family Medical Center); 2000	Julietta Perez-Cruz, Coordinator; Gaynell Winston and Leticia Vega, Co-Coordinators	213-746-1037 x 3325	jcruz@pedcenter.org
Santa Ana (UCI/Corbin Family and Community Center); 2000	Prof. Virginia Mann, Supervisor Maricela Sandoval and Gerardo Canul, Co-Coordinators	949-824-5296	msandoval@uci.edu mailto:vmann@uci.edu
Stockton (Charterhouse Center); 2001	Robin Apel	209-476-1106	apelfamily@yahoo.com
Turlock (Cal State University Stanislaus (2002, training in June)	Gary Novak, Supervisor; Emily Branscum, Coordinator	209-667-3386	Ebranscum@csustan.edu

Appendix C-7
ABC/CalSAHF:
The Sacramento County Birth & Beyond Program

Established in November 1999, Birth & Beyond (B&B) is a nine-site home visiting program based on the ABC/CalSAHF model (Answers Benefiting Children/California Safe and Healthy Families). Birth & Beyond was sparked by a series of high-profile child deaths in Sacramento County, high rates of infant mortality and child abuse and neglect, and the realization that something could be done to intervene to prevent these problems.

Birth & Beyond is a partnership of two County departments and several of their divisions (Child Protective Services, Alcohol and Other Drugs, Public Health Nursing, Mental Health, and California Work Opportunities and Responsibility to Kids (Cal-Works)) and private community-based organizations. The Sacramento County Family Support Collaborative is the oversight body, as designated by the Sacramento County Board of Supervisors. Five community-based nonprofit organizations, one school foundation, and one school district implement the program in nine sites. Currently, all nine sites have partnerships with local school districts.

The long-term goals of the Birth & Beyond program are to reduce child abuse and neglect; improve health outcomes, including infant and pre-term mortality; increase school readiness and school performance; and improve self-sufficiency of families in the County.

Services

Birth & Beyond provides support to families with children from pregnancy to age 5 (the criterion for eligibility is pregnancy or an infant up to three months of age) via home visits delivered by paraprofessionals, integrated multidisciplinary team case management, and family resource centers.

Sacramento County Birth & Beyond

- ABC/CalSAHF model
- Nine program sites, administered by five community-based agencies
- Home visits, multidisciplinary team, and family resource centers
- $11.8 million annual budget from multiple funding streams
- AmeriCorps members as home visitors
- External evaluation
- Joint training of home visitors in local community college
- Recipient of First 5 dollars

Home visits are slated on a weekly, fading to quarterly, schedule, depending upon family need. Eligible families include families with low income, lack of support, inadequate access to resources, many small children, or other risk factors. Families with active CPS cases are not eligible until their cases are closed.

After an initial screening to assess family needs, home visitors complete family support plans with each family, and these form the basis for services. Families are screened again every six months on measures of parenting and child rearing attitudes, maternal depression, social support, use of drugs and alcohol, and likelihood to use harsh discipline.

Family resource centers are a source of outreach for the home visiting program, provide classes and groups for families in and out of the home visiting program, and have a library of referral resources. Classes typically cover topics related to parent education, life skills, alcohol and drug issues, child abuse prevention, anger management, socializing, and birth preparation. The most frequently offered classes focus on parent education; the classes with the highest average attendance focus on life skills.

The Multidisciplinary Team (MDT) includes a family counselor, child development professional, public health nurse, alcohol and drug counselor, child welfare social worker, lactation specialist from WIC, domestic violence specialist, and CalWorks Specialist. They meet weekly to discuss all cases, and team members sometimes also visit families. The public health nurse, for example, routinely visits each family at least once.

Staffing and Caseload

This is a very large program. As of July 2002, there were 1,104 open home visitation cases, and 697 families (cumulative total) had visited the family resource centers.

Home visitors carry a maximum caseload of 15 families. Team leaders with masters level preparation in social work or counseling, or Public Health Nurses, supervise five home visitors, and two teams comprise the home visiting staff at each site. A program manager supervises each neighborhood site, including team leaders, home visitors, a group coordinator for the family resource center, and a data clerk.

An unusual feature of the B& B program is its use of AmeriCorps members as home visitors, as part of an initiative by the California Alliance for Prevention to employ AmeriCorps members in 19 counties to prevent child abuse and neglect. At each program site in Sacramento, half the home visitors are AmeriCorps members. They are integrated into the program and essentially are recruited and trained like any other staff members in this primarily paraprofessional home visiting model.

Program planners and administrators believe that the use of the AmeriCorps members has permitted a vast expansion of services and that the members have been able to introduce B&B to culturally and linguistically diverse families that would not otherwise have been reached by the program. In addition, the AmeriCorps members may serve as important role models for children in the community. Finally, the use of AmeriCorps members is seen as a way to build social capital, skills, and expertise within the community.

Evaluation and Quality Improvement

Birth and Beyond has modified the ABC/Cal-SAHF model by adding a continuous quality improvement and outcome evaluation component. Data are collected regularly to monitor program implementation and outcomes for children and families. The ongoing evaluation reveals the following results:

- *Child abuse and neglect*: Evaluators reviewed the case records of a random sample of 300 families who had been in Birth & Beyond at least 90 days. 35% of these families had some contact with Child Protective Services (CPS) for up to 5 years prior to entering Birth & Beyond. After enrollment, family involvement with CPS declined. For example, 13% of the families had substantiated reports of child maltreatment pre-enrollment, but that rate declined to 4% during the 300 families' participation in Birth & Beyond, and 9% among the 89 families who left the program. Equivalent results were found for families that had been served by AmeriCorps and non-AmeriCorps members.

- *Outcomes for parents – results of routine screenings*: As of October 2001, results of the routine screenings conducted by program staff demonstrate that parents are showing improvements in their attitudes toward parenting and child rearing and decreases in maternal depression (49% of mothers were depressed at enrollment). There were no changes in social support, or drug or alcohol use.

- *Service intensity*: Birth and Beyond provided 38,869 home visits since the program's inception through July 2002. Families averaged 2.3 visits per month, and the average visit lasted 55 minutes.

- *Staff retention*: Like many home visiting programs, B&B has worked hard to hire and retain good staff. Turnover among the home visitors was 73% during the first 19 months of the program, though rates have stabilized. AmeriCorps and non-AmeriCorps home visitors show equal rates of turnover.

- *Client attrition*: As of July 2002, 56% of the open home visitation cases had been open for more than 6 months, and 33% had been open for more than a year.

- *Value of the evaluation*: The data and MIS systems have been used to improve program practices. For example, data on referral rates and caseloads prompted program administrators to accelerate outreach to stimulate referrals and bring caseloads up to expected levels. Staffing stability data have been used to identify patterns and address persistent gaps. Sites have also used data to review follow-up with referrals, track and monitor caseloads, review the number of visits, and review individual case files.

Budget and Funding Sources

Funding has been derived from TANF Incentive Funds, Medi-Cal Administrative Activities, CAPIT (Child Abuse Prevention, Intervention, and Treatment), CBFRS (Community-based Family Resource & Support), PSSF (Promoting Safe and Stable Families), EPSDT (Early and Periodic Screening, Diagnosis, and Treatment), Targeted Case Management, AmeriCorps, and First 5 dollars. The 2002/2003 budget is about $11.8 million.

Successes and Next Steps

Program staff feel that the connection between home visiting and family resource centers is extremely beneficial for families. In addition, they note that those community agencies with a long history in the neighborhoods that they are serving may be accepted more readily by community residents – which makes it easier to enroll and retain families in services.

Birth & Beyond is working closely with the Sacramento City Unified School District, which was awarded a school readiness grant from the county First 5 Commission. The partnership will expand the relationship of Birth and Beyond with schools in three of its nine neighborhoods. The other six neighborhoods are already linked with other school districts.

As part of the early stages of the Birth & Beyond program, the evaluators (LPC Consulting Associates, Inc.) surveyed home visiting programs within the county, and some initial meetings were held to begin to develop coordinated plans for home visiting. These efforts continue and offer great promise for enhanced services for community members. Standards for home visitation programs are being prepared and standardized training will be developed, some of which may include community college courses.

For information about program services, contact:

Pat Mangan
Program Manager
Sacramento County Department of Health and Human Services
7001 East Parkway
Sacramento, CA 95823
Phone: 916-875-2020

For information about program evaluation, contact:

Lynne Cannady
LPC Consulting Associates, Inc.
PO Box 188529
Sacramento, CA 95825
Phone: 916-448-8026 FAX: 916-447-8780
e-mail: cannady@ford-consulting.com

APPENDIX D.
EXAMPLES OF COMMUNITY-WIDE INITIATIVES EMPLOYING HOME VISITATION

A few communities have implemented significant home visiting initiatives, with goals of reaching thousands of women each year. These initiatives are much larger than most of the efforts highlighted in Appendix C, and typically begin with a very inclusive, universal home visit, offered to all or most families without regard to income. The following describes two of these programs:

- The Every Child Counts Initiative in Alameda County, which offers 1-3 home visits for all newborns and intensive home visits to at-risk families;

- The Early Childhood Initiative of Cuyahoga County in Ohio, a county with about the same number of births annually as Alameda, and which also offers universal and targeted home visits, but which also has a broad community effort that includes health insurance, child care, special needs children, and public awareness campaign components

D-1. The Alameda County Children and Families Commission *Every Child Counts* Initiative *(www.ackids.org)*

The *Every Child Counts* (ECC) initiative seeks to provide family support services (prenatal services, home visits after birth, intensive family support, infant mental health, and school readiness) to all families with young children in the county. Home visiting services are provided in both a universal and targeted fashion:

(1) *Universal home visiting*: Hospital Outreach Coordinators (HOCs), stationed at four of the seven local birthing hospitals, offer one to three home visits to all families with newborns, regardless of family income or psychosocial risk factors.

The HOCs greet mothers, their newborns, and families in the hospitals and explain the home visiting program. If mothers provide written consents to participate and share program information, the HOCs make electronic referrals to the designated contractors for the provision of home visiting services.

Public health nurses conduct the first home visit within 48-72 hours of the initial referral. The home visiting model is relationship-based with specific protocols and curriculum designed to cover key domains as they are relevant to the mother and the family's life-course development.

(2) *Targeted home visits*: intensive family support services are provided for families with children who are medically fragile or who have referrals from the child welfare system, and for parents who are teenagers. *Special Start* is a joint project of

Children's Hospital Oakland and the Alameda County Public Health Department. Children's Hospital follows the medically fragile infants, and PHNs from the Special Start unit of the County follow the babies born who are determined to be at high social risk. In addition, with contracts from *Every Child Counts*, two agencies that serve teen mothers (the Perinatal Council and Tiburcio Vasquez Health Center) have expanded their Cal-LEARN and Adolescent Family Life Programs to provide more extensive family support services. Clients receiving intensive family support services can be followed up to the child's fifth birthday as necessary. The curriculum employed is "Growing Great Kids," a comprehensive curriculum that focuses on nurturing parent-child relationships and supporting healthy child development.

(3) *Another Road to Safety* focuses on families with children who are referred to the Social Services Agency Emergency Response Unit and are determined to be ineligible for SSA intervention services. Based upon geographic location, the families are referred from SSA to an ECC-contracted, community-based program and are offered intensive family support services for a period of up to nine months. The Structured Decision Making (SDM) tool is utilized to assess safety and risk. Family Advocates provide early intervention services using a staff to family ratio of 1:13.

The Specialty Provider Team is available for consultation on issues such as child development, substance abuse, and infant mental health to both the universal and intensive family support services components.

As reported in the 2001-2002 Annual Report of Every Child Counts, First Five Alameda County, fully 98% (3107) of families offered "universal" home visits accepted them. Of those, 99% signed consents to share information. Fully 2,371 families received visits. On average, each family received two visits. Under the intensive family support component, Children's Hospital Oakland provided home visiting services to 178 babies and their families. Visits ranged from 1 to 54 per client. 312 infants were served by the Public Health Department, and visits ranged from 1 to 35 per client. A total of 800 families were served by the teen parent component, with visits ranging from 1 to 64 per client. Another Road to Safety was in start-up during that period.

Satisfaction with home visiting services has been very high. Fully 98% of clients were very or somewhat satisfied with the family support service home visits, with the highest satisfaction levels among recipients of the Special Start home visits. 44% reported that they used services that they had learned about during their home visits.

For further information, contact:
Deborah Bremond, Ph.D.
Director of Family Support Services
Alameda County Children and Families First Commission
(510) 667-3140
ackids@alameda.ca.us

Profile of this program adapted from: Thompson, L., Kropenske, V., Heinicke, C., Gomby, D., & Halfon, N. *Home Visiting: A Service Strategy to Deliver Proposition 10 Results*, in N. Halfon, E. Shulman, and M. Hochstein, eds., Building Community Systems for Young Children, UCLA Center for Healthier Children, Families and Communities, 2001. Available at http://healthychild.ucla.edu.

D-2. Cuyahoga County, Ohio: The Early Childhood Initiative

The Cuyahoga County Early Childhood Initiative

- Illustrates a county-wide early childhood initiative that includes services similar to those funded in many counties by First Five dollars
- Initial commitment to a 3-year, $40-million, public-private initiative ($30 million public; $10 million private)
- All dollars pooled and controlled by public officials
- Multiple child- and adult-focused service strategies, including home visiting
- External evaluation for accountability and program improvement
- Illustrates the challenges inherent in scaling up services for an entire county
- Results over first two years:
  - 98% of children (birth to 5) now have health insurance
  - Over 13,300 home visits to first-time and teen mothers (85% eligible)
  - Over 3,800 families per quarter receive intensive home visiting
  - More than 9,000 new child care spaces created in newly-certified family child care homes
  - Technical assistance to child care providers on behalf of more than 650 children with special needs

Cuyahoga County in Ohio is home to the city of Cleveland. Over 18,000 women give birth each year. The annual per capita income was about $29,000 in 1998. The population is largely white (71%) and African-American (27%), with pockets of poverty and high-income enclaves.

The Cuyahoga County Early Childhood Initiative (ECI) is a public-private partnership designed to assure the well-being of all children birth through age five in the county. Launched on July 1, 1999, with a three-year commitment from its funders, the ECI seeks to promote and improve effective parenting, healthy children, and quality child care so Cuyahoga County's young children can achieve their maximum potential. The initiative is based on assumptions that (1) early preventive services are best; (2) services should be universal in nature, with more intensive services available for families at higher risk; (3) an initiative should be launched at scale so as to increase sustainability; and (4) evaluation can serve important program improvement and accountability functions.

The ECI's Goals, Services, and Funding

The ECI seeks to produce effective parents, healthy children, and quality child care. Specific outcomes include the following:

Health and Safety
- Increases in the number of children with health insurance and a medical home
- Increases in the number of children receiving appropriate medical services
- Increases in the number of children who receive their immunizations by age five
- Reductions in child abuse and neglect
- Decreases in child deaths

Child Development
- Earlier identification and referral of children with developmental delays
- Increases in the number of children enrolled in Head Start or public preschool
- Increased availability of certified child care
- Increased availability of child care for children with special needs.

Economic Self-Sufficiency
- More economically self-sufficient families

These goals are addressed through a network of health, home visiting, and child care services, as well as through a public education campaign:

- *Welcome Home*: Within two weeks of a child's birth, a home visit by a registered nurse for all teen mothers and for all first-time mothers in the county
- *Early Start*: Regular home visits to families with children up to age three where parents need additional support.
- *Quality Child Care*: Recruit, train, certify, and retain home-based family child care providers to assure an adequate supply of quality child care for children birth through age five.
- *Special Needs Child Care*: Technical assistance for parents and child care providers to help them care for children who require special assistance to remain in child care.
- *Healthy Start*: Free health insurance for children of low-income families via Medicaid and SCHIP; connect children to a "medical home," where they can receive regular well-baby visits and screening for developmental delays and disabilities.
- *Early Childhood Awareness Campaign*: Countywide campaign to provide caregivers and the general public with basic information about the physical, emotional, cognitive, and social development of children via radio spots, a Family Helpline, coloring books for children, and other outreach materials.

Both public and private dollars for the ECI are pooled and controlled by county commissioners, with the advisory input of a Partnership Committee. The Committee meets quarterly and is comprised of the three county commissioners, representatives of

the state of Ohio, and one representative from each of the 23 participating foundations and corporations.

Integral to the ECI is a commitment to evaluation and to continuous quality improvement, as evidenced by county-produced quarterly reports, and an external evaluation, coordinated by researchers from Case Western Reserve University and Chapin Hall and including researchers from the University of North Carolina, Chapel Hill. Results of the first year of the evaluation focused primarily on process and revealed that the ECI had met or exceeded almost all its performance goals.

Universal Home Visiting: Welcome Home

The Welcome Home visit is the most popular element of the ECI. It affords all first-time or teen mothers in Cuyahoga County a home visit by a trained nurse within the first two weeks after the baby's birth. During the first two years of the ECI, over 13,000 families were visited (approximately 85% of eligible families). About one-quarter of all families visited were referred on to more intensive Early Start home visits or Early Intervention services.

Recipients of the home visits are overwhelmingly satisfied with the visits and with their Welcome Home nurse home visitor: They believe their time with their home visitor is well-spent (98%), and that their home visitor is sensitive (100%), easy to talk to (97%), and provides good ideas (100%). Because the program was available to all first-time and teen mothers, no matter their income levels, the Welcome Home program has had great reach, and many in the community, including funders and policymakers have friends or relatives who have enjoyed a visit by a Welcome Home nurse.

Home Visiting Services in Cuyahoga County

- ***Welcome Hom***e: All first-time or teen mothers receive minimum of one visit by a nurse
- Extremely popular
- 25% of families referred to more intensive home visiting
- ***Interlink***: centralized intake process. Interlink assigns all families referred for intensive home visiting to one of 27 county-contracted agencies for intensive home visiting services, tailored to initial needs
- ***Early Start***: Home visits weekly, then declining in frequency, depending upon family needs
- ***Quality control*** process established: all agencies now undergoing quality audit, with performance standards established

Intensive Home Visiting: Early Start

Early Start home visits are delivered to families who are at higher than average risk for poor outcomes, based on demographic characteristics such as low income, teen parent, or high level of stress. In addition, all TANF recipients of the county with children up to one year of age now receive automatic referrals to Early Start. The Early Start caseload is approximately 3,800 families during any one quarter.

Families that are referred for Early Start home visits move through a centralized intake process, dubbed Interlink, and are matched with one of 27 agencies in the county that has been tapped to deliver Early Start home visiting services. The agencies have different strengths, and a unique feature of the ECI model is the notion that the

neutral Interlink function will be able to match families with home visiting provider agencies that best can meet their needs. A quality improvement effort has been instituted to make sure that participating families receive high quality services, no matter to which agency they have been assigned.

Other ECI Services

The ECI also involves efforts to recruit, train, prepare for certification, and then support and help retain family child care providers; to help children with special needs secure child care; insure all birth- to 5-year-olds; and make the public aware of the importance of early childhood years. Results over the first two years include the following:

- Creation of 9,000 new spaces for children in certified family child care homes.
- About 76% of 3- and 4-year-olds in the County are now enrolled in preschool, Head Start, or other settings.
- Technical assistance was provided for 650 children with special needs to help them remain in child care.
- The number of children from birth to age 5 in the county who are uninsured fell from about 10% in 1998 to about 2% in 2001. After two years, over 6,000 more children had health insurance (via Medicaid or SCHIP) than when the ECI began.
- The public awareness campaign employed radio announcements, a newsletter for new parents, trayliners, bookmarks, and other approaches to reach hundreds of thousands of women in Cuyahoga County.

For further information about the Cuyahoga County Early Childhood Initiative, contact:

Molly Irwin
Assessment and Evaluation Manager
Early Childhood Initiative of Cuyahoga County
Family and Children First Council
112 Hamliton Avenue, Room 600
Cleveland, OH 44114
Phone: (216) 698-2214
e-mail: CNMEI@www.cuyahoga.oh.us

APPENDIX E.
FREQUENTLY ASKED QUESTIONS ABOUT HOME VISITING

The following are some commonly asked questions about home visiting services:

1. Should We Launch a Home Visiting Program to Promote School Readiness?
2. What Home Visiting Model Should Be Selected?
3. Does Who Administers the Program Make a Difference?
4. Should Programs Focus on Just a Few Goals or Should They Be Broad and Comprehensive?
5. When Should Services Begin? How Long Should They Last? How Intensive Should They Be?
6. Whom Should We Hire as Home Visitors?
7. Should We Target Services to Particular Groups or Offer Them Universally?
8. How Much Does Home Visiting Cost, and How Can We Pay for Services?
9. What Can We Do to Maintain Program Quality?
10. What Can We Expect?

The answers to these questions, which distill the lessons learned from the most important research findings, appear below:

1. Should We Launch a Home Visiting Program to Promote School Readiness?

The answer depends upon the goals for the program and the community.

Goals. If the proposed goals are primarily to promote cognitive child development, then center-based early childhood education programs provide larger and more consistent benefits than do home visiting programs. If the proposed goals are to promote parenting skills and prevent child abuse, then home visiting programs may be helpful, especially if complemented by parent groups.

Why? Because home visiting programs are primarily parent-focused programs. Services are directed at the parent and seek to change the parent's behavior (e.g., parent education about child development, encouraging parents to go back to school, helping parents find stable housing). Even programs that have explicit goals to promote child development usually rely on parents' changing their behavior (e.g., reading to their children every day, talking with their children in ways that promote their development, working through prescribed "homework" activities with their children) as the means of promoting child development. So, child development gains cannot be seen unless parents change their behavior, and, even if parents do change, it may take some time before changes will be seen in children.

Furthermore, families typically receive no more than 40 hours or so of home visiting services a year, and sometimes much fewer than that. That is not a lot of time in which to persuade parents to change a complex set of behaviors related to parenting, especially if

parents have not specifically sought out information about parenting and do not believe they need to change.

In contrast, center-based early childhood education programs such as preschool offer services, focused directly on children, for 20 to 40 hours per child over the course of a single week. That provides much more attention directly on child development, and directly on the child, not mediated by parents.

Therefore, as might be expected, research indicates that (1) home visiting programs more often produce benefits in outcomes related to parenting than in outcomes related to child development, and (2) center-based early childhood education programs produce gains in children's cognitive development as much as four or five times greater than those produced by home visiting programs.

That said, there is also evidence that parent support groups produce equivalent and perhaps larger benefits for parents than do home visits. But, the parents who enjoy home visits are not necessarily the same who attend group meetings, and vice versa. Therefore, communities that offer parents multiple service strategies may show the largest eventual benefit.

If the proposed goals relate to child health, then it is probably more important to make sure that children are insured and have access to health services than to launch a new home visiting program. Home visiting programs do not consistently promote better or more appropriate use of preventive health services, perhaps because the effects of health insurance and the availability of convenient health services (both of which are largely driven by federal, state, and local policy decisions) are so much larger than the effects that can be generated by advice that home visitors give families about the importance of preventive health care. In other words, even if parents are persuaded by their home visitor to take their children for a well-baby check-up or to be immunized, but their children are not eligible for insurance or health services are several bus rides away, then their use of preventive health care services is unlikely to change.

Community. In some places such as small, rural communities, center-based early childhood education programs are not feasible. There are too few children to make a center economically feasible, or families live so far apart from one another that they would be unwilling to travel to a center.

In other, perhaps most, communities, families may be unwilling to place their very young infants and toddlers in a center-based early childhood education program. And, the quality of much infant and toddler child care is such that it may not benefit children very much anyway.

Finally, if the goal is to reach families who are extremely isolated socially, then home visiting may be a way to reach them before children enter school.

In these communities and for these families, a home-based program can be one of the only ways to even have a chance of bringing school readiness-related services to families.

2. What Home Visiting Model Should Be Selected?

Abt Associates has reviewed the family support literature from 1965 through 2000 and concludes, "There is no single effective program model…. there is no single program approach, curriculum or service strategy that has demonstrated effectiveness across a range of populations." Models that have been tested in different communities and with different populations usually show a range of effects, and even models such as the Nurse-Family Partnership, which arguably has shown the most positive effects in rigorous randomized trials, do not always generate the same magnitude effects across all population groups or across all measures.

Therefore, the best way to select a home visiting program is to choose a model that has demonstrated benefits on goals that you are interested in addressing, with families similar to the families that you are trying to serve, and living in communities similar to yours.

For example, some programs focus primarily on low-income women who are pregnant with their first child, while others seek to reach all families with children under age 3 in a community. Some programs focus primarily on preventing child maltreatment, others on child development, and still others on moving families from welfare to work.

These are very different programs, with very different goals. Do not expect that one program will generate the same effects as another, just because they both rely on home visiting as a primary service strategy.

Programs may state that they address all these goals, and perhaps others as well. But, consider what the program is at its essence, because, if home visitors are only able to complete about half the visits they have planned (which is about typical), they may only be able to deliver the high notes of the program's curriculum. What does the curriculum content suggest will be the primary area of program focus in an abbreviated program? It may be that only some of the program goals will be able to be addressed.

In addition, consider the extent to which programs depend upon other services for their success. If, for example, home visits focus on parents' self-sufficiency and rely on center-based early childhood education to promote child development, then communities must have high quality child care, or the whole package of services will not lead to benefits in child development.

3. Does Who Administers the Program Make a Difference?

Yes. Different agencies that administer the same model can create programs that differ in how they operate, in how families perceive them, in the outcomes they produce, and in the complementary services that families receive.

For example, evaluators of Hawaii's Healthy Start program (the forerunner of the Healthy Families America program) discovered the families left the program at its different sites at differing rates, ranging from 38-64% over the first year. The different attrition rates were attributable to different philosophies held by the three administering agencies regarding how hard to try to hold onto families. In the agency with the highest attrition rate, the staff believed that it was more important to serve families that really wanted to participate than to try to hold onto more reluctant participants. In the agency with the lowest attrition, the staff believed that it was precisely the hard-to-reach families that needed help the most, and they worked very hard to retain those families. Clearly, parents would experience the program differently at each site.

Similarly, staff training and background leads to differences in what families hear from their home visitors. The test of the Nurse-Family Partnership in Denver, for example, suggested that paraprofessional home visitors spent more time during their home visits talking with families about pregnancy planning, education, work, and family material needs, while nurses spent a greater portion of their home-visit time on physical health during pregnancy and on parenting after delivery. Home visitors with training in child development might spend more time talking about those issues. Again, families might experience the same program differently, depending upon who their home visitor is – and those hiring decisions are often related to which agencies are operating the programs.

Some suggest that families may also perceive programs differently, depending upon the administering agency. For example, families may view programs operated out of a county social service agency suspiciously because they may fear home visitors are scrutinizing them for evidence of child maltreatment. Among community-based organizations, an agency with a long history and good reputation in the community may be more likely to enroll and retain families.

Programs administered by school districts, as many Home Instruction for Parents of Preschool Youngsters (HIPPY) and Parents as Teachers (PAT) programs are, may also produce different benefits, such as greater parent involvement in their children's education in later years or greater support for school district bonds in elections. In other words, such programs may break down barriers that parents may feel toward schools and instead encourage them to become supporters of education and the schools.

Finally, programs that are operated out of multi-service agencies may be more likely to refer families to complementary services, and the families may be more likely to receive them. For example, a study of Parents as Teachers in three inner-city communities suggested that the home visiting program that was co-located with other services might have been the most effective of the sites.

This is the promise offered by co-locating home visiting programs with family resource centers or on school-sites, and states such as Connecticut have spent millions to co-locate home visiting programs such as Parents as Teachers in school-based family resource centers, but there is no research yet on the comparative advantage of these arrangements.

4. Should Programs Focus on Just a Few Goals or Should They Be Broad and Comprehensive?

The National Academy of Sciences concludes, "Widely implemented programs that have extended their services beyond home visiting to provide a mix of adult education, job training, parenting education, and child care have also yielded, at best, modest results, particularly when they do little to address the multiple risk factors that often characterize the families they are trying to reach and do not focus extensive resources on addressing the parent-child relationship."

Again, the explanation may lie partially in the number of hours that are spent with families. It is probably not possible for programs to address family economic needs, parenting, child development, as well as other issues in the two or three hours each month that home visitors spend with each family.

Even if it were, it is unlikely that a single home visitor will be equally skilled in addressing all these issues. Some programs have responded to this by creating a team approach, with different staff members assigned different responsibilities. In Early Head Start, for example, home visitors were not always able to address their child development focus, because parents wanted to talk about broader family needs. Some programs spent as little as 20% of their time on child development, although others spent more. Some Early Head Start sites have responded by having home visitors focus on child development and other staff -- resource specialists -- focus on family needs. Child involvement was reported highest in programs that provided family development services in separate home visits and in programs that planned activities using the Parents as Teachers curriculum (which the evaluators report facilitates direct involvement with the child). The Cal-SAHF approach, which employed multidisciplinary teams, exemplified this approach.

Whether the program's stated goals are focused or comprehensive, however, may not matter as much as how home visitors translate those goals into action. Programs produce benefits in those outcomes on which home visitors focus. For example, an evaluation of a Healthy Families America program in San Diego revealed that health-related outcomes improved after mid-course training for home visitors led them to emphasize health issues during their visits.

5. When Should Services Begin? How Long Should They Last? How Intensive Should They Be?

Onset: Prenatal enrollment affords some advantages in programs that seek to begin services around the time of birth. Pregnant women may be especially receptive to intervention as it is a natural time to have questions and concerns about their own health as well as the health and development of their babies. If services begin before birth, then it is possible that the rapport between home visitor and parent will be stronger – and perhaps will last longer. Interim results from Early Head Start suggest that prenatal enrollment is associated with larger benefits for more outcomes, and the Nurse-Family Partnership, which has produced some of the largest benefits for families, begins prenatally.

Duration and Intensity: Generally, in early childhood programs, more intensive and longer-lasting services produce larger benefits for children. Some home visiting programs have responded by trying to extend home visiting services for the first five years of a child's life (e.g., Parents as Teachers). However, only a minority of families typically remain enrolled for that length of time. In fact, in most programs, 30-40% of families have left the program by the end of two years, and 50-70% may have left by three years. In addition, most families typically receive fewer home visits, often only half as many, as they are scheduled to receive. Programs that schedule weekly visits often can only complete a little over two visits per month.

Researchers do not know what the minimum number or intensity of visits is needed before results can be generated, but these practical truths about the delivery of home visits suggest that programs might more profitably attempt a relatively intensive intervention during the early months of a family's involvement than to try to hold onto families for many years.

In other words, rather than monthly home visits for 3 years, it might be better to try for weekly home visits for six months, then fading to twice per month for 2 years. Even if these levels of service are not achieved, and they probably will not be, programs should be staffed to permit them because that will allow the possibility of increasing service levels if a family enters a crisis and needs some extra time and attention.

6. Whom Should We Hire as Home Visitors?

Home visitors are the central figures in any home visiting program. They recruit families, deliver the curriculum, link families with other services, and encourage and support them in their efforts to change. The success of the program rides on the shoulders of home visitors, and there is no decision so important as the hiring decision about a home visitor.

Hiring decisions should be driven by program goals, design, and home visiting model. For example, the Nurse Family Partnership model specifies that the home visitors must

be nurses. The HIPPY and Parent-Child Home Program specify that home visitors be drawn from the same population as are participating families.

But, in many other program models, the decision is left up to the individual program sites. Benefits have been found in home visiting programs that use visitors with many different backgrounds, including those that use paraprofessionals. And, most experts agree that the most important skills for a home visitor are not necessarily skills that are derived from an educational degree. For example, a description of the skills needed in a home visitor in the Teenage Parent Home Visitor demonstration program included the following: "A thorough understanding and support of the purposes of the intervention; an ability to plan and execute visits that successfully build on clients' behaviors; sound judgment and maturity; good listening and observing skills; an ability to communicate effectively by asking appropriate questions and accurately interpreting responses; knowledge of how to assess risks; knowledge of local resources; and the ability to effectively interact with other professional service providers."

However, more and more programs are turning toward using individuals with more training and educational experience. Healthy Families America, for example, began as a paraprofessional home visiting program, but now, over 80% of the home visitors in its program sites are individuals with college attendance or degrees, typically in child development, social work, nursing, or education.

Paraprofessionals are usually advocated for three primary reasons: (1) they are thought to have a better understanding of the families that are being served, and so will be better able to engage families and will therefore produce greater benefits; (2) they earn less than professionals, and so program costs can be kept lean; and (3) the advancement of paraprofessionals is sometimes a specific program goal.

But, research and practical experience suggest that paraprofessionals can present some extra challenges too. Because paraprofessionals are usually paid modest wages, they may be more likely than higher-paid workers to leave programs for jobs that pay more. Some research indicates that the turnover rate among paraprofessionals may be especially high. That results in increased costs for programs as they must hire and retrain new workers at a faster rate. In home visiting programs, where the success of the intervention hinges upon the ability of home visitors to form rapport with families, turnover can be very damaging. In addition, because this may be the first job for many paraprofessional home visitors, they may need extra supervision and assistance to master basic job skills.

For many programs, therefore, the true cost of employing paraprofessionals winds up being about as high as employing professionals. That means that the main reasons to hire paraprofessionals should be because they are better at engaging and serving families, and/or because hiring paraprofessionals is part of the mission of the program (e.g., HIPPY or PCHP).

The nature of the home visiting program plays a part in this, too. Some programs such as HIPPY and the Parent-Child Home Program have fairly well-specified curricula and

more routinized lesson plans. Others rely to a far greater extent upon the experience and skills of the home visitor to work with families to develop individualized services that span a wide range of goals. For those far-reaching programs, it may be best to rely upon workers who have more training, background, and experience, than to rely upon relative newcomers to the field. For example, evidence from an evaluation of the broad-ranging Nurse-Family Partnership suggests that, for that program model, paraprofessionals produced benefits for families that were about half as large as the benefits produced by nurses.

7. Should We Target Services to Particular Groups or Offer Them Universally?

This is an important issue because if the groups that benefit most could be predicted, then services could be more efficiently and effectively delivered.

Some home visiting programs are offered universally, that is, to every mother with a child in a certain age range, who lives in a particular geographic area. Other programs specifically focus on particular groups where eligibility is fairly broad and based on easily observable characteristics (e.g., low-income women pregnant with their first baby). Still other programs use screening questionnaires that combine demographics with scores on tests of mental health status or stress levels to identify mothers who are at higher-than-average risk for poor outcomes of one sort or another, such as child abuse and neglect. In practice, however, funding is rarely sufficient to cover all eligible families, and even universally available programs often prioritize services to those families judged to be at higher risk or more in need.

Many programs are better able to retain some subgroups of families, and some families benefit more than others from a given home visiting program. But, there is little consistency across program models and program sites in who those families are. For example, the Nurse-Family Partnership targets services to low-income, unmarried women because research results indicate that such women benefit most, and that the program only pays off economically when delivered to that group. The program also appears to generate extra benefits for those women who possess low psychological resources (low IQ, poor coping skills, and poor mental health) upon enrollment. Evaluations of other home visiting programs identified other groups as benefiting most or engaging more fully in program services: Spanish-speaking children of Latina mothers in one PAT site; higher educated and higher income mothers in one evaluation of HIPPY; African-American and first-born children in the early years of an evaluation of Early Head Start.

Several researchers have suggested that the most at-risk families, defined in a variety of ways, may benefit most. If so, this might be because home visiting services help place a supportive floor underneath the neediest families, or because those families feel the strongest need and motivation to change. For example, researchers have suggested that home visiting programs that target children with special biological or developmental needs have especially strong effects on children’s cognitive and social-emotional

outcomes, perhaps because parents are especially determined to help these children with clear and obvious needs for special assistance.

Or, perhaps the effects of home visiting programs can be observed most easily among the group that is the neediest because that group has the most room for improvement. In other words, one can only create large change in a group that possesses high rates of the behavior to be changed.

Or, perhaps, home visitors recognize the neediest families in their caseloads and find a way to offer them more intensive services. For example, families who had low psychological resources at baseline in the Elmira site of the Nurse Family Partnership were the families who benefited most from the program, but they were also the families who received the most visits and contacts from home visitors.

Although it is probable that some families will prefer and benefit from one model of home visiting services over another, little research has been conducted to clarify which families will benefit most from any single home visiting model. Research does, however, clearly suggest that in-depth home visiting programs will not produce benefits across the whole population of families with young children. Intensive, universal home visiting will not lead to broad benefits. The benefits of a single initial home visit to all families, or to a broad range of families, have not been evaluated, although experience in some communities (e.g., Cuyahoga County, Ohio – See Appendix D), suggests that such home visiting programs are extremely popular.

For programs that employ a screening instrument, there are some additional cautions. Most programs that use screening instruments use them as a way to identify families at high-risk for child abuse and neglect, but most panels and research reviews have specifically recommended against the use of screening instruments for that purpose. Screening instruments may be accurate for a brief time, but family circumstances can change, and the screen could easily miss families whose risk profile changes over the course of a few years. And, if screens identify too many families who are not really at-risk, families may experience unwarranted stigmatization.

Even if screening instruments are accurate, programs must make sure that program services address the risk factors identified through the screening instrument. For example, results of the Nurse Family Partnership (which does not use a screening instrument) indicated that it did not prevent child abuse among families with high rates of domestic violence, resulting in a revision of the NFP curriculum. But, domestic violence might be one of the very risk factors that would screen a family into another home visiting program, and that program too might not have the services in place to help the family. Research suggests that home visitors often feel awkward or uncomfortable addressing several family issues that are often embedded in screens: domestic violence, mothers with mental illness, especially depression, and substance abusing families. If programs do not have curricula concerning those problems, or if home visitors are not at ease in dealing with them, then program goals are unlikely to be achieved, and the initial screens will not have accomplished their purposes.

8. How Much Does Home Visiting Cost, and How Can We Pay For Services?

Generally, the cost of home visiting programs ranges from $1,300 to $5,000 per family per year, largely depending upon personnel costs, but very comprehensive programs such as Early Head Start, might cost as much as $11,500 per family per year. A recent review summarizes annual program costs per family for several of the large home visiting models as follows (all in 1998 dollars):

$1,341 for HIPPY
$2,118 for PAT
$2,203 for Healthy Families America
$2,995 for Hawaii's Healthy Start
$2,842-$3,249 for the Nurse-Family Partnership (costs are less after three years, when all nurses are trained and full caseloads attained)

More recent estimates, provided by the national offices for some of these programs, suggest that the cost of the Parent-Child Home Program may be about $2,000 per year; and $3,000 - $5,000 for Healthy Families America.

Depending upon the services offered, home visiting programs have employed Medicaid, State Children's Health Insurance Program (SCHIP), Title V Maternal and Child health Services Block Grant, TANF, U.S. Department of Education, Head Start, California Department of Education, Even Start, Title I, local and county funding, First 5 dollars, and funding from private foundations and corporations.[i]

Fully 80% of the program costs are direct costs for personnel. The main drivers of program costs include staff qualifications/experience; home visitor caseload; number, frequency, and duration of visits; travel distance and mode of transportation; training, supervision, and administration; record-keeping and service documentation; and parent participation time.

In time studies of how home visitors spent their time across several programs, it appears that home visits account for only a small percentage of their time: perhaps 25% in a Monterey County PAT program, 10-33% in other programs. Home visitors spend most of their time on administration and paperwork. This suggests that programs should examine the ways in which they are staffed, and find ways to cut down on home visitor paperwork (perhaps using other staff to handle some of the details).

[i] For more information about funding for home visiting programs, see Thompson, L., Kropenske, V., Heinicke, C.M., Gomby, D.S., & Halfon, N. (December 2001) *Home Visiting: A Service Strategy to Deliver Proposition 10 Results*, in N. Halfon, E. Shulman, & M. Hochstein, eds. Building Community Systems for Young Children, UCLA Center for Healthier Children, Families, and Communities. Available at http://healthchild.ucla.edu. Also, Cornell, E. (June 14, 2002). The benefits and financing of home visiting programs. NGA Center for Best Practices. Issue Brief. Available at: http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF%5ED_3927,00.html

9. What Can We Do to Maintain Program Quality?

Even the best-designed home visiting program can founder if services are not implemented well. The key contributors to program quality are the following:

- family engagement,
- the delivery of the curriculum,
- the skills and abilities of home visitors to forge relationships with the families,
- cultural consonance between the program and its clientele, and
- developing appropriate responses to those high-risk families that are facing depression, substance abuse, or domestic violence.

Engagement: between 10% and 40% of families who are invited to enroll in intensive home visiting services decline. As many as 50-70% of families leave home visiting programs before services are scheduled to end. Families often receive only about half the visits they are scheduled to receive, and usually not more than two visits per month.

Curriculum: the program curriculum must address directly the goals that the program is designed to achieve, and the curriculum must be delivered with fidelity. In other words, if the program seeks to promote child development, then services must provide families with tools that will directly promote the development of their children. Further, home visitors must understand and endorse the program goals, or services are unlikely to be effective.

Home visitors: Home visiting programs rise and fall on the skills of their visitors. Some programs provide as much as 6 months of intensive pre-service training for their visitors, others provide as little as a week or two. Programs vary in their caseloads and in their levels of supervision for home visitors.

Cultural consonance: Most home visiting programs seek to influence parenting behavior, but there is probably no aspect of family life that is as culturally-bound as is parenting behavior. Research is limited on the parenting practices that are best across cultures and families of different races and ethnicities. But, there are strong suggestions that programs that do not treat different beliefs about parenting with respect and understanding will not be successful. On the other hand, toning down clear messages merely to keep families enrolled will not help programs achieve their goals.

Special families: Families may face some problems that require special attention because they have especially negative consequences for family functioning and for children. But, these are precisely the areas that most evaluations suggest that home visitors feel awkward about or ill-equipped to address: substance abuse, maternal depression, domestic violence, and contraception.

But, if programs do not deliver high quality services, families will not benefit. Therefore, program sites, program funders, and national program offices should all take steps to build high quality services.

To address these issues of implementation, individual program sites should:

1. Make sure that they adhere to program standards established by the national headquarters for their program model. If programs are not affiliated with a national model, then they should make sure that they establish standards for the key components of program quality listed above.

2. Monitor performance on program standards regularly and provide feedback to staff.

3. Seek out opportunities for cross-site comparisons and learning.

4. Try rapid improvement cycles, in which approaches to quality problems are tried for a few months, data are collected to monitor their effects, and, if successful, the new approaches are implemented. If they are not successful, then other approaches are tried.

Program funders and funding agencies should:

1. Support the costs of program monitoring and quality improvement, including data collection, MIS development, data analysis and feedback to program sites.

2. Explore the development of common definitions for key program quality components (e.g., terms such as enrollment, attrition, missed visit, reasons for exit, paraprofessional).

3. Require reporting around key program quality components, using common definitions if they have been developed, or asking programs to include their definitions if common definitions are not yet developed.

4. Support opportunities for rapid improvement cycles.

The national offices for key home visiting models should:

1. Develop performance standards for their models that address issues of engagement (including enrollment, service frequency, attrition rates, and involvement of families in complementary services such as parent group meetings); staff background, training, caseloads, and supervision levels; cultural consonance; and addressing families with special needs. Developing definitions for terms related to engagement are especially important because these terms are used very differently across models and program sites.

2. Require program sites to feed information back to the national offices on some or all of these performance standards.

3. Develop feedback mechanisms to deliver information back to program sites so that each site will be able to see how its performance compares with that of other sites that serve similar populations.

4. Offer technical assistance to sites that fall below stated performance standards. Such technical assistance could take the form of peer support, in which staff from program sites learn from one another and perhaps visit sites that excel.

5. Monitor the aspects of quality that are associated with better outcomes for children and families at as many sites as possible.

10. What Can We Expect?

The very mixed results from home visiting research suggest that programs cannot always expect to produce the same results as did the model demonstration programs upon which the program was based. To even have a chance of replicating those results, however, programs should be replicated at the same funding levels as in the original demonstration programs (because those control staffing and caseloads), and employing the same curricula and staffing patterns.

However, no matter the care involved in the replication, expectations for program success should be modest, because behavior change is hard to achieve, and home visiting is a fragile means by which to achieve it. Home visiting programs use perhaps 20-40 hours of contact to try to alter the behavior of individuals as a way of addressing large societal problems such as child abuse and neglect, lack of school readiness, and teen pregnancy, and they struggle with problems of implementation all along the way.

Families are most likely to adopt changes when the change is easy to make, clearly defined, and/or results in a clearly visible change. For example, placing children on their backs to sleep is a behavior change that is easy to explain and that is relatively easy for parents to implement. Many other changes, such as reading to an infant every day or changing vocabulary and conversation styles to elaborate upon a toddler's speech patterns, are more complicated to explain, to model, and to learn, and they require a great deal more effort on the part of parents to implement.

Home visiting programs also sometimes serve families who may not see the need to change their behavior. When mothers see all the children in their neighborhood at about the same developmental level as their own children, when they see their relatives rearing their children the same way they do, when they see their neighbors struggling with the same work, husband, boyfriend, and money issues they have, then they may not see the need or have the motivation to change.

How much more difficult, too, is change when the problems are societal or community-wide. If families live in communities where poverty is entrenched, then programs that

focus solely on individual change rather than broader policy solutions may be out-matched.

In sum, policymakers and practitioners should maintain modest expectations for home visiting services. Because home visiting programs will not and cannot serve the needs of all families, other service strategies should be offered to complement home visiting services and to help families and children who opt out of home visiting services. These may include more child-focused services (such as child care), parent-focused services that are delivered in another way (e.g., parenting classes delivered in the community or on the job site), or other policy alternatives designed to increase the connections between parents and children.